OMB #: 0938-0707
Exp. Date:

MODEL APPLICATION TEMPLATE FOR STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT STATE CHILDREN'S HEALTH INSURANCE PROGRAM

Preamble

Section 4901 of the Balanced Budget Act of 1997 (BBA) amended the Social Security Act (the Act) by adding a new title XXI, the State Children's Health Insurance Program (SCHIP). Title XXI provides funds to states to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner. To be eligible for funds under this program, states must submit a state plan, which must be approved by the Secretary. A state may choose to amend its approved state plan in whole or in part at any time through the submittal of a plan amendment.

This model application template outlines the information that must be included in the state child health plan, and any subsequent amendments. It has been designed to reflect the requirements as they exist in current regulations, found at 42 CFR part 457. These requirements are necessary for state plans and amendments under Title XXI.

The Department of Health and Human Services will continue to work collaboratively with states and other interested parties to provide specific guidance in key areas like applicant and enrollee protections, collection of baseline data, and methods for preventing substitution of Federal funds for existing state and private funds. As such guidance becomes available, we will work to distribute it in a timely fashion to provide assistance as states submit their state plans and amendments.

MODEL APPLICATION TEMPLATE FOR STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT STATE CHILDREN'S HEALTH INSURANCE PROGRAM

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

State/Territory: Iowa_____
(Name of State/Territory)

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, **(42 CFR, 457.40(b))**

_____
(Signature of Governor, or designee, of State/Territory, Date Signed)

submits the following State Child Health Plan for the State Children's Health Insurance Program and hereby agrees to administer the program in accordance with the provisions of the approved State Child Health Plan, the requirements of Title XXI and XIX of the Act (as appropriate) and all applicable Federal regulations and other official issuances of the Department.

The following state officials are responsible for program administration and financial oversight **(42 CFR 457.40(c))**:

Name: Jessie K. Rasmussen	Position/Title: Director, Iowa Department of Human Services
Name: Deb Bingaman	Position/Title: Division Administrator, Division of Financial Health and Work Supports
Name: Anita Smith	Position/Title: Bureau Chief, Bureau of Health Insurance

Section 1. General Description and Purpose of the State Child Health Plans and State Child Health Plan Requirements (Section 2101)

1.1 The state will use funds provided under Title XXI primarily for (Check appropriate box) **(42 CFR 457.70)**:

1.1.1 ☐ Obtaining coverage that meets the requirements for a separate child health program **(Section 2103)**; **OR**

1.1.2. ☐ Providing expanded benefits under the State's Medicaid plan **(Title XIX)**; **OR**

1.1.3. X A combination of both of the above.

Medicaid Expansion (M-CHIP)

Effective July 1, 1998

- Children ages 15 through 18 in families with income between 37 percent and 100 percent of Federal Poverty Level (FPL). These are the "Waxman" children that are being phased-in to Medicaid as a mandatory coverage group. Beginning October 1, 2002, all of these children will be covered under Medicaid.
- Children ages 6 through 18 in families with income that is equal to or less than 133 percent of FPL.

Effective July 1, 2000

- Infants, up to one year of age, in families with income between 185 percent and 200 percent of FPL.

The State has implemented systems changes that allow for identification of children eligible for Medicaid via CHIP so they can be reported separately from children eligible for Medicaid via the 1902(r)(2) Medicaid State Plan Amendment. This will allow CHIP eligible children (optional targeted low-income children) to be reported and claimed at the enhanced rate and other newly eligible children to be reported and claimed at the State's standard FMAP.

Children eligible for Medicaid as a result of the expansion receive health care services through the same delivery systems that operate in the Medicaid program.

Separate Program: Healthy And Well Kids In Iowa (***hawk-i***) Program (S-CHIP)

The Healthy And Well Kids in Iowa (***hawk-i***) program covers targeted low-income children up to age 19 in families who income does not exceed 200% of the FPL.

Effective January 1, 1999, the State implemented the ***hawk-i*** program for targeted low-income children up to age 19 in families who income was at or below 185% of the federal poverty level (FPL). The State expanded coverage to 200% of the FPL effective July 1, 2000.

The ***hawk-i*** program has several components and is designed to encompass a variety of entry points into the program. The delivery of services follows a private sector commercial insurance model.

Iowa Department of Human Services: The Department of Human Services (DHS) has been designated as the State agency to administer the ***hawk-i*** program.

hawk-i Board. The Iowa General Assembly authorized the creation of the ***hawk-i*** Board to provide direction to the Department of Human Services and to establish policy for the program. The ***hawk-i*** Board is made up of eleven members:

- Director of the Iowa Department of Public Health or their designee
- Director of the Iowa Department of Education or their designee
- Commissioner of the Iowa Division of Insurance or their designee
- Four Governor-appointed public members
- Four ex-officio legislators (2 Senate/2 House of Representatives)

Third Party Administrator: The Department of Human Services has contracted with a third party administrator to provide, at a minimum, the following services:

- Distribute applications
- Determine eligibility
- Screen for Medicaid eligibility and coordinate with co-located Medicaid eligibility workers.
- Calculate, bill, and collect cost sharing.
- Assist the family in selecting a health plan and enrolling the child in the selected plan.
- Gather encounter data from the health plans.
- Provide DHS with demographic, statistical, and encounter data for federal reporting and other reporting requirements.

Advisory Committees: Three advisory committees have been established to provide input to the ***hawk-i*** Board. The Clinical Advisory Committee is made up of health care professionals who advise the ***hawk-i*** Board on issues around benefits, access, and quality. The Children With Special Health Care Needs Advisory Committee is made up of health care professionals and advocates who advise the ***hawk-i*** Board on health

care issues faced by children with special needs and make recommendations on how to address those needs. The Quality Assessment and Improvement Advisory Committee is made up of members of the Clinical Advisory Committee who advise the ***hawk-i*** Board on clinical issues, quality improvement and utilization management.

Health Plans: The Department of Human Services contracts with health plans licensed by the Division of Insurance within the Department of Commerce to provide health care coverage to eligible children under the ***hawk-i*** program.

The University of Iowa Public Policy Center: The Department of Human Services contracts with the University of Iowa Public Policy Center to conduct analysis of the functional health assessment and analysis of the encounter data.

1.2 X Please provide an assurance that expenditures for child health assistance will not be claimed prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS. **(42 CFR 457.40(d))**

1.3 **X** Please provide an assurance that the state complies with all applicable civil rights requirements, including Title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35. **(42CFR 457.130)**

1.4 Please provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this plan or plan amendment **(42 CFR 457.65)**:

Effective date: Medicaid Expansion 5-1-1998
hawk-i 7-1-1998

Implementation date: Medicaid Expansion 7-1-1998
hawk-i 1-1-1999

Section 2. General Background and Description of State Approach to Child Health Coverage and Coordination (Section 2102 (a)(1)-(3)) and (Section 2105)(c)(7)(A)-(B))

2.1. Describe the extent to which, and manner in which, children in the state including targeted low-income children and other classes of children, by income level and other relevant factors, such as race and ethnicity and geographic location, currently have creditable health coverage (as defined in 42 CFR 457.10). To the extent feasible, make a distinction between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements). **(42 CFR 457.80(a))**

Historically, Iowa is a rural, agricultural state. However, recently there has been a shift in population from rural areas to urban centers. New estimates from the U.S. Census Bureau show that population growth in Iowa during the 1990's is confined to two areas: in and around Des Moines, and in the Cedar Rapids/Iowa City corridor. At the same time, 45 of Iowa's 99 counties are losing population. Data from 1994 suggests that 44 percent of Iowans live inside a metropolitan area.

According to the 2000 U.S. Census, Iowa has a population of 2,926,324 with 23.8% (827,983) being children ages 19 and younger. The Census reports show 11.5% of Iowa's population or 336,527 people living below poverty. In general, the highest levels of poverty are in the southern counties along the Missouri border.

While approximately 2,747,818 (93.9%) of Iowa's population are white and 61,423 (2.3%) are black, Iowa is experiencing an ever emerging diverse population. For Iowa's children ages 19 years and younger, the percentages of different races varies from the total population. The children are 90.9% white, 3% black or African American, 0.4% American Indian or Alaska Native, 2% are of other race and 2.2% are two or more races. There are 36,263 Hispanic children (can be of any race) in Iowa.

Additionally, Iowa is becoming home to more and more refugees from all areas of the world. Most recently, Iowa has had significant numbers of Sudanese and Bosnians settle in some of the larger urban centers of the State.

Estimate Number of Refugees and Amerasians in Iowa

Region of Origin	Number Who Originally Settled in Iowa
Africa	
Sudanese	773
All other ethnicities	719
Near East	
Iraqi	144
All Others	99
Former Soviet Union	
All ethnicities	443
Eastern Europe	
Bosnian	4,611
Kosovar	185
All other ethnicities	361
Southeast Asia	
Vietnamese	7,383
Tai Dam	2,740
Lowland Lao	3,281
Cambodian/Khmer	840
Hmong	423
Latin America/Caribbean	
Haitian	32
All other ethnicities	5
TOTAL	**21,988**

The Mesquaki Tribe is the only Federally recognized Native American Tribe in Iowa. It is a subset of the Sac and Fox of the Mississippi and Iowa Tribe and currently has 1,277 enrolled members. The improving economic conditions on the Mesquaki Settlement, primarily due to casino revenue, has resulted in a significant growth trend and 200% birth rate increase since 1992. According to the 2000 U.S. Census, 8,989 people identified themselves as Native American or Alaska Native. Of this number 39.1% are 19 years of age or younger.

The only public health insurance program generally available in Iowa is Medicaid. In April 2002, there were 129,192 children (66,369 male/ 62,823 female) receiving coverage through the Medicaid program.

The Iowa Caring Program for Children, a primarily privately funded, Wellmark (Blue Cross Blue Shield of Iowa and South Dakota) sponsored program, covered about 3,000 children below 133% of FPL. This program covered uninsured children who

did not qualify for Medicaid. With the expansion of Medicaid and implementation of the ***hawk-i*** program, the Caring Program ceased their program operations on July 1, 1999.

2.2. Describe the current state efforts to provide or obtain creditable health coverage for uncovered children by addressing: **(Section 2102)(a)(2) (42CFR 457.80(b))**

2.2.1. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in public health insurance programs (i.e. Medicaid and state-only child health insurance):

Medicaid

The Medicaid program is the only public health insurance program for children in Iowa. Medicaid is administered through the Department of Human Services (DHS) Central Office in Des Moines and through 104 DHS offices (including the Refugee Services Center) located in all 99 counties. Additionally, outstationed eligibility workers are currently located-at Broadlawns Hospital in Des Moines. The University of Iowa in Iowa City has 6 intake positions.

There are five Federally Qualified Health Centers (FQHC) in Iowa. Currently there is one outstationed eligibility worker position at each of these sites.

Medicaid applications are readily available to anyone who requests one. Additionally, there is a toll-free number for anyone to call and ask questions about Medicaid eligibility and to find how to apply. The number is 1-800-869-6334.

In April 2000, Iowa had 129,192 children with health care coverage through the Medicaid program. Eligibility for Medicaid continues to remain available for the following federal categories of children. Those who qualify because they would have been eligible for cash assistance prior to July 16, 1996, and related categorical programs; those who are in foster care and subsidized adoption; those who qualify for the Mothers and Children program (SOBRA); those who meet disability criteria; those who are medically needy, and those who qualify under the following home and community based waivers:

	Enrollment Cap
♦ Ill and Handicapped Waiver	1660
♦ Mental Retardation Waiver	2348(for children) + 100 ICF/MR beds
♦ Brain Injury Waiver	372
♦ AIDS Waiver	50
♦ Physical Disability Waiver	144
♦ Elderly Waiver	Dependent on number of clients enrolled and amount of reimbursement for clients

Health Insurance Premium Payment Program (HIPP)

Iowa was one of the first states to implement the provisions of section 1906 of the Social Security Act which mandated states to purchase employer-related health insurance coverage for Medicaid-eligible persons when it was determined cost-effective to do so. Iowa implemented the Health Insurance Premium Payment (HIPP) program on July 1, 1991. Although section 1906 of the Social Security Act has now become optional, Iowa continues to maintain a strong HIPP program. Although this program is primarily designed to reduce Medicaid expenditures by providing a third party resource for Medicaid-eligible persons, oftentimes it is cost-effective to purchase family coverage which results in providing coverage for the non-Medicaid eligible household members as well. By initiating coverage while on Medicaid, families have coverage in place when they leave the Medicaid roles.

Direct Health Services (Title V, Title X, WIC, etc.)

The Iowa Department of Public Health (IDPH) is the largest single provider of direct as well as support patient care for uninsured and Medicaid enrolled children and adolescents. Direct services for this population include: preventive child health services (EPSDT) and well-child check-ups, prenatal services, Women, Infants and Children Supplemental Nutrition (WIC) program services, preventive health education, immunizations, and family planning services. Support services include case coordination services, the provision of information and referral via toll-free telephone lines, and laboratory services. These services are funded through federal Title V Maternal and Child Health Block Grant funds, federal Title X Family programming funds, federal WIC Program funds, Medicaid program reimbursements, federal immunization funds, state legislative appropriations, some local government appropriations, and a small amount of patient fee revenue collected on a sliding fee scale by Title V agencies. A variety of the above direct and support services are provided within each of the 99 Iowa counties. Twenty-six Maternal Health Centers and twenty Child Health Centers provide statewide services. Adolescent services are provided in 25 locations in the state.

Additionally, there are approximately 486 full-time school health nurses working under the auspices of the Iowa Department of Education and local education agencies in the state who provide a variety of health screening services, care coordination and emergency services.

Income assessments are performed on patients enrolled in IDPH clinics. The income assessments are reviewed for possible Medicaid eligibility. New applications, as well as annual reviews of established patients, are assessed by

IDPH intake staff and/or care coordinators for possible referral for medical assistance through Medicaid and/or SSI.

In order to provide additional outreach, The IDPH operates two toll-free telephone lines for use by the general public. The toll-free telephone lines are known as Healthy Families and Teen Line. These are information and referral services for health issues. The Healthy Families line addresses a wide variety of health issues with emphasis on prenatal care. The Teen Line also addresses a variety of issues specifically related to the health of teenagers. Topics covered include drugs, sexual relationships, eating disorders, relationships with parents, and violence. Two integral parts of the information provided to callers, via these telephone lines, are information on Medicaid eligibility and referrals to community based care coordinators who can assist clients with locating local health providers who accept Medicaid-eligible children an Medicaid-eligible pregnant women. The toll-free number for Health Families is 1-800-369-2229. The Teen Line number is 1-800-443-8336. Both lines are operational 24 hours a day, seven (7) days a week.

Child Health Specialty Clinics

Each year, approximately 5,500 Iowa children receive services at the Child Health Specialty Clinics (CHSC). The Department of Human Services has an interagency cooperation agreement with the CHSC which serve as a link between major medical centers and the community by assisting families to obtain needed resources. The CHSC serves children from birth to 22 years with or at risk of a chronic health condition or disability, which includes psychosocial, physical, health-related educational, and behavioral needs. The specific health concerns may be simple or complex, short-term or long-term.

Small Group Insurance Reform

Iowa enacted small group reforms in 1992. These reforms provided more affordable coverage for the small group market, thus allowing employees and their dependents to obtain coverage at more affordable rates. The reforms included limitations on rate increases as well as limitations on pre-existing condition clauses.

In 1996, Iowa implemented individual market reforms which provide for portability for employees and their dependents form a group to the individual market, as well as rating restrictions on individual products.

State High Risk Insurance Pool

Iowa law established a state administered high-risk health insurance program for those individuals and their dependents who cannot obtain coverage in the

private market. This program is funded by a 2% tax on health insurance premiums. Persons who are eligible for Medicaid or COBRA continuation coverage are not eligible to participate in this program. Coverage in the high-risk program provides for individuals to the private market.

2.2.2. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in health insurance programs that involve a public-private partnership:

Currently there are no health insurance programs that involve a public-private relationship.

The Caring Program for Children

There was one health insurance program in Iowa that resembled a public-private partnership. However, it was not administered by the State. This program was known as the Caring Program for Children and was administered by Wellmark (Blue Cross and Blue Shield of Iowa and South Dakota). The Iowa Caring Foundation provided ambulatory health insurance to low income, non-Medicaid/uninsured children under the age of 19 years who remain full-time students through grade 12. During its 10 years of operation, the Caring Foundation was funded through a state appropriation and private donations, with matching funds from Wellmark. At its peak the Caring Program had an enrollment of over 3000 children. The Caring Program ceased operation on June 30, 1999.

2.3. Describe the procedures the state uses to accomplish coordination of SCHIP with other public and private health insurance programs, sources of health benefits coverage for children, and relevant child health programs, such as Title V, that provide health care services for low-income children to increase the number of children with creditable health coverage. *(Previously 4.4.5.)*
Section 2102)(a)(3) and 2102(c)(2) and 2102(b)(3)(E)) (42CFR 457.80(c))

At the time a child is determined not to be eligible for ***hawk-i***, the letter the applicant receives states: "Although you child does not qualify for ***hawk-i***, health care services may be available through your local child health agency. For information about the child health center in your area, please call 1-800-369-2229 (Iowa Healthy Families Information and Referral Service)."

When it is determined that a child will no longer qualify for Medicaid, a referral is made to ***hawk-i***. This referral includes the name of the child (or children), the Medicaid end date, the reason for referral, and a copy of the notice of decision. This referral serves as an application to the ***hawk-i*** program.

The third party administrator performs a comparison of ***hawk-i*** enrollees to Medicaid enrollees. A file containing the Medicaid enrollees is received and matched daily with the ***hawk-i*** enrollee file. If a match is found, the child is cancelled from ***hawk-i*** after being given notice of the cancellation.

If a individual applying for health services through a public health clinic also wishes to apply for Medicaid or ***hawk-i***, the public health clinic will forward this information to ***hawk-i*** within two working days.

If an individual applying for WIC services also wishes to apply for Medicaid, the WIC agency will forward the information to Medicaid. If an individual applying for WIC appears to qualify for ***hawk-i***, the individual is given a ***hawk-i*** enrollment form.

If a child applying for ***hawk-i*** is determined to be eligible for Medicaid, a referral for EPSDT is made. If a child or family asks about WIC, a WIC brochure along with the location of the nearest WIC is given to them .

In the action plans of the Title V agencies in Iowa, the Title V agencies have included outreach to ***hawk-i*** and Medicaid to children who may be eligible. The agencies will identify these children, notify the families of the program and advise them where and how to enroll and how to maintain the enrollment.

The Iowa Department of Human Services will be entering into a contract with the Iowa Department of Public Health to conduct grassroots outreach for the ***hawk-i*** and Medicaid programs. The Iowa Department of Public Health who oversees the Title V agencies, will ask the Title V agencies to either conduct the grassroots outreach activities or to subcontract with an agency or organization to do outreach. The Title V agencies will be responsible for doing a gap analysis to see what community agencies are currently doing for outreach as well as determine what is missing. The action plans must include the results of the gap analysis and what steps the agency will take to involve the community in conducting outreach.

Section 3. Methods of Delivery and Utilization Controls (Section 2102)(a)(4))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan**, and continue on to Section 4.

3.1. Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of the choice of financing and the methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations. **(Section 2102)(a)(4) (42CFR 457.490(a))**

Healthy And Well Kids in Iowa (***hawk-i***) Program

The State has entered into contractual agreements with commercial insurers to provide a benchmark equivalent benefit package to enrollees in the ***hawk-i*** program. The insurer will provide the enrollee with a health plan card identifying them as an enrollee in that health plan. The enrollee will have a primary care physician if they are in a managed care plan.

Both indemnity and managed care plans are allowed to participate in the program. The goal is to allow choice among plans so that enrollees can select the health plan from which they want to receive coverage. Both indemnity and managed care plans receive a monthly capitation payment for each ***hawk-i*** enrollee in the plan. The State contracts with indemnity plans only in those counties where the State does not have a contract with a managed care plan. If the State enters into a contract with a managed care plan in a county where the State currently has a contract with an indemnity plan, the ***hawk-i*** enrollees of the indemnity plan shall remain enrolled with the indemnity plan until the expiration of the twelve-month enrollment. All enrollees eligible for the ***hawk-i*** program after the execution of the contract with the managed care plan shall be enrolled with the managed care plan.

3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children. Describe the systems designed to ensure that enrollees receiving health care services under the state plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved state plan. **(Section 2102)(a)(4) (42CFR 457.490(b))**

Healthy And Well Kids in Iowa (*hawk-i*) Program

Health plans are allowed to establish limits for services and implement utilization management guidelines such as requiring prior authorization and using drug formularies as long as the plan provides the required services and meets benchmark equivalency. Plans may not deny coverage due to the existence of a pre-existing medical condition.

The State conducts periodic evaluations of each health plan for the purpose of reviewing the policies and procedures for utilization management, appeals and grievances, contract compliance, health education programs and materials, and the quality improvement program

Section 4. Eligibility Standards and Methodology. (Section 2102(b))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan,** and continue on to Section 5.

4.1. The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. **(Section 2102)(b)(1)(A)) (42CFR 457.305(a) and 457.320(a))**

4.1.1. X Geographic area served by the Plan: The State has been divided into six regions for the purpose of establishing plan participation (See Attachment 1). If a health plan wants to provide coverage in any county within a region, it must provide coverage in every county within that region in which it licensed and has a provider network established. Under ***hawk-i***, managed care plans can only provide coverage in those areas of the state in which they are licensed and in which a provider network is established.

Effective July 1, 2001:

John Deere Health Plan is providing coverage in the following Iowa counties:

Black Hawk	Cedar	Dubuque	Johnson	Polk
Benton	Clayton	Grundy	Jones	Scott
Bremer	Dallas	Iowa	Linn	Warren
Butler	Delaware	Jackson	Madison	Washington

Classic Blue (Wellmark Blue Cross Blue Shield of Iowa) is providing coverage in the following Iowa counties:

Adair	Crawford	Harrison	Osceola	Shelby
Adams	Davis	Henry	Mills	Sioux
Allamakee	Decatur	Howard	Mitchell	Taylor
Appanoose	Dickinson	Humboldt	Monona	Union
Audubon	Emmet	Ida	Monroe	Wapello
Buena Vista	Fayette	Iowa	Page	Wayne
Carroll	Floyd	Jasper	Palo Alto	Webster
Cass	Franklin	Jefferson	Plymouth	Winnebago
Cerro Gordo	Fremont	Keokuk	Pocahontas	Winneshiek
Cherokee	Greene	Kossuth	Pottawattamie	Woodbury
Clarke	Guthrie	Montgomery	Poweshiek	Worth
Clay	Hancock	O'Brien	Sac	Wright

Iowa Health Solutions is providing coverage in the following Iowa Counties:

Benton	Clinton	Jackson	Mahaska	Scott
Boone	Des Moines	Lee	Marion	Story
Buchanan	Dubuque	Linn	Marshall	Tama
Calhoun	Hamilton	Louisa	Muscatine	Van Buren
Clayton	Hardin	Lucas	Polk	Warren

4.1.2. X Age: Under ***hawk-i***, children up to the age of 19 are covered. Coverage ends effective the first day of the month following the month of the nineteenth birthday.

4.1.3. X Income: Effective July 1, 2000, under ***hawk-i***, countable earned and gross unearned income cannot exceed 200% of the FPL for family of the same size. Effective December 1, 1999, 20% of earned income (including self-employment income) will be exempt when determining family income for the ***hawk-i*** program.

Income from self-employment: under ***hawk-i***, income from self-employment will be the gross income minus the cost of doing business. This includes the depreciation of capital assets as identified for income tax purposes.

4.1.4. ☐ Resources (including any standards relating to spend downs and disposition of resources):

4.1.5. X Residency (so long as residency requirement is not based on length of time in state): Under ***hawk-i***, the child must be a resident of the State of Iowa. There is no minimum period of time in which the child must reside in the State to establish residency. A resident is one:

a. Who is living in Iowa voluntarily with the intention of making that person's home in Iowa and not for a temporary purpose; or
b. Who, at the time of application, is not receiving assistance from another state and entered Iowa with a job commitment or to seek employment or who is living with parents or guardians who entered Iowa with a job commitment or to seek employment.

4.1.6. ☐ Disability Status (so long as any standard relating to disability status does not restrict eligibility):

4.1.7. X Access to or coverage under other health coverage: A child who is covered under other health insurance is not eligible for coverage under ***hawk-i*** unless the coverage is a single service coverage such as a dental

only or vision only policy. Access to coverage is not considered if the child is not actually covered.

4.1.8. X Duration of eligibility: Eligibility for ***hawk-i*** is granted in 12-month enrollment periods. At the end of the 12 months, a review is completed to establish eligibility for the next 12-month enrollment period.

4.1.9. X Other standards (identify and describe): Pregnancy. During the 12-month enrollment cycle, if a child enrolled in the ***hawk-i*** program becomes pregnant, Medicaid eligibility will be determined. If eligible, the pregnant child will be transferred to the Medicaid program. If Medicaid eligibility does not exist, eligibility will continue under ***hawk-i***.

Inmates of nonmedical public institution. At the time of application or annual review of eligibility, the child shall not be an inmate of a nonmedical public institution as defined at 42 CFR Section 435.1009 as amended November 10, 1994.

Inmates of institutions for mental disease. At the time of application or annual review of eligibility, the child shall not be an inmate of an institution for mental as defined at 42 CFR 435 Section 435.1009 as amended November 10, 1994.

4.2. The state assures that it has made the following findings with respect to the eligibility standards in its plan: **(Section 2102)(b)(1)(B)) (42CFR 457.320(b))**

4.2.1. X These standards do not discriminate on the basis of diagnosis.
4.2.2. X Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.
4.2.3. X These standards do not deny eligibility based on a child having a pre-existing medical condition.

4.3. Describe the methods of establishing eligibility and continuing enrollment. **(Section 2102)(b)(2)) (42CFR 457.350)**

Initial Enrollment

Applications for the ***hawk-i*** program are received via mail by the third party administrator at a central location in Des Moines, Iowa.

Applications are screened for completeness of information, the presence of other health insurance, verification of income, the presence of State of Iowa employment,

and Medicaid eligibility. If it appears that child is Medicaid eligible, the original application is referred to a Medicaid eligibility worker co-located at the third party administrator's office for a Medicaid eligibility determination. (See Attachment 2)

Upon receipt of a completed application, the third party administrator must determine ***hawk-i*** eligibility within 10 working days. If it is determined the child is uninsured, that countable income is below the ***hawk-i*** limit, and that the child otherwise qualifies, a notice of approval is sent to the family. Included with the approval notice is information about the health plans available to the family and a Plan Selection form on which the family must make their selection. If countable income exceeds 150% of FPL, the family is also required to pay a premium of $10 per month per child, not to exceed $20 per month, regardless of family size. Cost sharing is not assessed to American Indian or Alaska Native children, regardless of income.

Upon receipt of the Plan Selection form and the premium (if applicable), the third party administrator notifies the health plan of the new enrollment. If the Plan Selection form is not returned by the due date, the third party administrator randomly assigns the family to a health plan. The family has thirty days to notify the third party administrator if they want to change the health plan. The health plan provides an identification card, an explanation of coverage, and a list of participating providers to the family.

Ongoing Eligibility During the 12-Month Enrollment

Once eligibility is established, the child shall remain enrolled in the ***hawk-i*** program for a 12-month enrollment period unless one of the following occurs:

a. The child moves to an area of the state not served by that plan. In which case, the child shall be enrolled in a participating plan in the new location. The enrollment period is the remaining months of the original 12-month enrollment.
b. Age. The child shall be disenrolled from the ***hawk-i*** program as of the first day of the month following the month of the nineteenth birthday.
c. Nonpayment of premiums. The child shall be disenrolled as of the first day of the month following the month in which premiums are not paid. If the family reports a decrease in income during the 12-month enrollment period, premium cost sharing is re-evaluated. If the family's income is reduced below 150 percent of FPL, the family will not have to pay a premium for the remaining months of the enrollment period.
d. Iowa residence is abandoned. The child shall be disenrolled from the plan and canceled from the program as of the first day of the month following the month in which the child relocated to another state.
e. Medicaid eligibility. The child shall be disenrolled from the plan and canceled from the program as of the first day of the month following the month in which Medicaid eligibility is attained.

f. Enrolled in other health insurance. The child shall be disenrolled from the plan as of the first day of the month following the month in which the child attains other health insurance coverage.
g. Admission to a nonmedical public institution. The child shall be disenrolled from the plan and canceled from the program as of the first day of the month in which the child enters a nonmedical public institution unless it can be established that the absence is temporary.
h. Employment with the State of Iowa. The child shall be disenrolled from the plan and canceled from the ***hawk-i*** program as of the first day of the month in which the child's parent becomes eligible to participate in a health plan available to State of Iowa employees.

Recertification

All eligibility factors are reviewed annually as follows:
a. Sixty (60) days prior to the end of the 12-month enrollment period, the third party administrator mail a ***hawk-i*** renewal application form to the family. The renewal application form is preprinted with the information known about the household. The family is asked to verify the correctness of the information and return the corrected form with current income verification. A postage-paid return envelope is provided.
b. If the family fails to return the information or required income verification, the child shall not be recertified for the next 12-month enrollment period.
c. Upon a determination that the child continues to meet all eligibility factors, the family shall be allowed to select another plan for the next 12-month enrollment period if another plan is available. If the family does not select another plan, the child shall be re-enrolled with the current plan for the next 12-monthe enrollment period.

4.3.1 Describe the state's policies governing enrollment caps and waiting lists (if any). **(Section 2106(b)(7)) (42CFR 457.305(b))**

☐ Check here if this section does not apply to your state.

When the Department has established that all of the funds appropriated for this program are obligated, the third-party administrator shall deny all subsequent applications for ***hawk-i*** coverage unless Medicaid eligibility exists.

a. The third-party administrator shall mail a notice of decision. The notice shall state that:
(1) The applicant meets the eligibility requirements but that no funds are available and that the applicant will be placed on a waiting list, or
(2) The person does not meet eligibility requirements. In which case, the applicant shall not be put on a waiting list.

b. Prior to an applicant's being denied or placed on the waiting list, the third-party administrator shall refer the application to the Medicaid program for an

eligibility determination. If Medicaid eligibility exists, the department shall approve the child for Medicaid coverage in accordance with 441—86.4(514I).

c. The third-party administrator shall enter applicants on the waiting list on the basis of the date a completed Form 470-3564 is date-stamped by the third-party administrator. In the event that more than one application is received on the same day, the third-party administrator shall enter applicants on the waiting list on the basis of the day of the month of the oldest child's birthday, the lowest number being first on the list. The third-party administrator shall decide any subsequent ties by the month of birth of the oldest child, January being month one and the lowest number.

d. If funds become available, the third-party administrator shall select applicants from the waiting list based on the order in which their names appear on the list and shall notify them of their selection.

e. After being notified of the availability of funding, the applicant shall have 15 working days to confirm the applicant's continued interest in applying for the program and to provide any information necessary to establish eligibility. If the applicant does not confirm continued interest in applying for the program and does not provide any additional information necessary to establish eligibility within 15 working days, the third-party administrator shall delete the applicant's name from the waiting list and shall contact the next applicant on the waiting list.

At the point it is known that Iowa will need to implement a waiting list, DHS will notify the ***hawk-i*** Board and CMS giving as much advance notice as possible. DHS will also notify issue a press release for public notice indicating when the waiting list will be implemented.

4.4. Describe the procedures that assure that:

4.4.1. Through the screening procedures used at intake and follow-up eligibility determination, including any periodic redetermination, that only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance coverage (including access to a state health benefits plan) are furnished child health assistance under the state child health plan. **(Sections 2102(b)(3)(A) and 2110(b)(2)(B)) (42 CFR 457.310(b) (42CFR 457.350(a)(1)) 457.80(c)(3))**

Refer to response in 4.3.

4.4.2. The Medicaid application and enrollment process is initiated and facilitated for children found through the screening to be potentially eligible for medical assistance under the state Medicaid plan under Title XIX. **(Section 2102)(b)(3)(B)) (42CFR 457.350(a)(2))**

Refer to response in 4.3.

4.4.3. The State is taking steps to assist in the enrollment in SCHIP of children determined ineligible for Medicaid. **(Sections 2102(a)(1) and (2) and 2102(c)(2)) (42CFR 431.636(b)(4))**

Refer to response in 4.3.

4.4.4. The insurance provided under the state child health plan does not substitute for coverage under group health plans. Check the appropriate box. **(Section 2102)(b)(3)(C)) (42CFR 457.805) (42 CFR 457.810(a)-(c))**

4.4.4.1. X Coverage provided to children in families at or below 200% FPL: describe the methods of monitoring substitution.

A child who is currently enrolled in an individual or group health plan is not eligible to participate in the ***hawk-i*** program. **Exception:** A child who is enrolled in a single service plan that provides coverage only for a specific disease or service (e.g. dental only or vision only) is considered uninsured for the purpose of establishing ***hawk-i*** eligibility.

The State imposes a 6-month waiting period of uninsured children who have been insured through an employer group health plan in the six months prior to the month of application unless good cause for the current uninsured status exists. Good cause exists when:

a. Employment was lost for a reason other than voluntary termination; or
b. Coverage was lost due to the death of a parent; or
c. There was a change in employment to an employer who does not provide an option for dependent coverage; or
d. The child moved to an area of the state where the existing plan does not have a provider network established; or
e. The employer discontinued health benefits to all employees; or
f. The coverage period allowed by COBRA expired, or
g. The parent became self-employed; or
h. Health benefits were terminated because of a long-term disability; or
i. Dependent coverage was terminated due to an extreme economic hardship on the part of either the employee or the employer. Extreme economic hardship for employees shall mean that the employee's share of the premium for

providing employer-sponsored dependent coverage exceeds 5 percent of the family's gross annual income;or

j. There was a substantial reduction in either lifetime medical benefits or a benefit category available to an employee and dependents under a employer's health care plan; or
k. SCHIP coverage in another state was terminated due to the family's move to Iowa.

4.4.4.2. ☐ Coverage provided to children in families over 200% and up to 250% FPL: describe how substitution is monitored and identify specific strategies to limit substitution if levels become unacceptable.

4.4.4.3. ☐ Coverage provided to children in families above 250% FPL: describe how substitution is monitored and identify specific strategies in place to prevent substitution.

4.4.4.4. ☐ If the state provides coverage under a premium assistance program, describe:

The minimum period without coverage under a group health plan, including any allowable exceptions to the waiting period.

The minimum employer contribution.

The cost-effectiveness determination.

4.4.5 Child health assistance is provided to targeted low-income children in the state who are American Indian and Alaska Native. **(Section 2102)(b)(3)(D)) (42 CFR 457.125(a))**

American Indian and Alaska Native Children are eligible for the ***hawk-i*** program on the same basis as any other children in the State, regardless of whether or not they may be eligible for or served by Indian Health Services-funded care. No premiums or other cost sharing apply to American Indian or Alaska Native children.

Section 5. Outreach (Section 2102(c))

Describe the procedures used by the state to accomplish:

Outreach to families of children likely to be eligible for child health assistance or other public or private health coverage to inform them of the availability of the programs, and to assist them in enrolling their children in such a program: **(Section 2102(c)(1)) (42CFR 457.90)**

Grassroots Outreach

In July of 1999, the ***hawk-i*** Board directed the Iowa Department of Human Services to develop a grassroots outreach effort. The Department developed a plan by which communities would bring together those individuals and entities that touch the lives of families with children in order to develop a community outreach strategy. Once the plan was developed, it was submitted to the Department for approval and funding was made available to assist in the implementation plan. Currently, the Department has 53 community outreach contracts that cover 89 counties.

Covering Kids Grant Project:

Covering Kids is a 3-year grant that was awarded to the Iowa Department of Public Health in 1999 by the Robert Wood Johnson Foundation. The purpose of the grant is to increase access to health care coverage for all uninsured and underinsured children in Iowa. Administrators of the grant work collaboratively with the Iowa Department of Human Services, the Iowa Department of Education, advocates, medical providers, and others to address barriers to access for uninsured and underinsured children. This grant expires on June 30, 2002. As of July 1, 2002, the Iowa Department of Public Health will continue this work under a new 4-year Robert Wood Johnson Covering Kids and Families grant.

Mass Media Campaign

During the spring of 2001, a short-term mass media campaign was used. Television commercials that had been produced for the national Insure Kids Now effort were used. Commercials were aired in both English and Spanish. Also a 60-second radio commercial in English and Spanish was produced. The commercials were aired for a seven-week period during March, April and May. There was an immediate response to the media campaign. During the six-month period prior to the campaign, the ***hawk-i*** customer service center received an average of 400 application requests per month. During the three months in which the commercials aired, application requests averaged 1,500 per month.

Other Media

Ads have been placed in the Qwest Dex directory, in the yellow pages as well as the internet listing ***hawk-i*** 's toll free number. Ads have also occurred in various local and state newsletters, magazines, and other publications.

Parterning with Schools

The Department of Human Services and the Department of Education collaborated to develop an interagency agreement that allowed schools and child care providers who participate in the Free and Reduced Meals Program to make referrals to the ***hawk-i*** Program for outreach purposes. Under this initiative, the names of applicants for the Free and Reduced Meals Program are referred to the ***hawk-i*** Program unless the family specifically asks not to be referred. Participating schools submitted a list of names to the ***hawk-i*** customer service center and then the customer service center mailed an application and information to the families. During the first year of this effort, applications were mailed to approximately 6,000 families. The Departments are working together to ensure this will be an ongoing effort.

Literacy Project

Iowa was one of seven states selected to participate in a literacy project being conducted by the Centers for Medicare and Medicaid Services. The purpose of the project was to evaluate applications, brochures and other state-produced materials to assess how they could be modified to ensure comprehension by persons with very low literacy levels. Additionally, materials written in non-English languages were evaluated to see if they would meet the needs of the populations for which they were intended. These findings are being utilized in the study to redesign the ***hawk-i*** application and brochure in order to remove as many barriers to enrollment as possible.

Multi-Language Poster

The Department of Human Services introduced a new multi-language ***hawk-i*** poster in October 2001 in order to ensure that the needs of persons with limited English proficiency were being met. The poster provides information about the program in five languages: English, Spanish, Bosnian, Vietnamese, and Laotian. It also informs that translator services are available to assist them applications. The need for translation of information into these specific languages was identified through input of local outreach workers, the Bureau of Refugee Services, and use of AT&T translator lines by the ***hawk-i*** customer service center.

Corporate Involvement

Nationally, there has been a growing interest by large corporations to assist states in promoting their SCHIP Program. Iowa actively takes advantage of these efforts to further promote the program. Some of these efforts in Iowa included:

- Wal-Mart/Pampers
- H&R Block
- The Mar**maxx**

In addition to the outreach activities aimed at enrolling eligible children, the state agencies' existing efforts to promote the use of health care services and continuity of care will also be expanded to include the new Title XXI enrollees. These activities include use of the media, case management, and patient follow-up systems, (especially within the Title V, Title X and Title XX Block Grant Programs, and related programs for children within the Iowa Department of Human Services).

Case management consists of a variety of activities designed to identify an individual patient's psychosocial needs and barriers to obtaining health services (such as enrolling in Medicaid), and assist the patient in meeting those needs and accessing services. Patient follow-up includes a variety of activities designed to ensure that patients comply with the recommendations of their health care provider(s) and continue in the health system.

One example of Iowa's continuing effort to improve the health status of school-aged children, the Project Success Program, coordinates social and health services with parental involvement in 13 designated school sites in the Des Moines school district. Project Success sites, which include seven elementary schools, two middle schools, two high schools, and two alternative high schools, refer potentially eligible Medicaid children for eligibility determination. Additionally, sixteen schools based/linked clinics provide services to school-aged children, their siblings and preschool aged children in the district. The clinics are required to assess income levels and refer those children who appear to be Medicaid eligible for eligibility determination while at the same time providing needed medical services.

Section 6. Coverage Requirements for Children's Health Insurance (Section 2103)

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state Medicaid plan**, and continue on to Section 7.

6.1. The state elects to provide the following forms of coverage to children: (Check all that apply.) **(42CFR 457.410(a))**

6.1.1. ☐ Benchmark coverage; **(Section 2103(a)(1) and 42 CFR 457.420)**

6.1.1.1. ☐ FEHBP-equivalent coverage; **(Section 2103(b)(1))** (If checked, attach copy of the plan.)

6.1.1.2. ☐ State employee coverage; **(Section 2103(b)(2))** (If checked, identify the plan and attach a copy of the benefits description.)

6.1.1.3. ☐ HMO with largest insured commercial enrollment **(Section 2103(b)(3))** (If checked, identify the plan and attach a copy of the benefits description.)

6.1.2. X Benchmark-equivalent coverage; **(Section 2103(a)(2) and 42 CFR 457.430)** Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Please attach a signed actuarial report that meets the requirements specified in 42 CFR 457.431**. See instructions.**

See Attachment 3 for the benchmark plan.
Effective July 1, 2001, these are the health plans currently participating in the ***hawk-i*** program.

John Deere Health Plan (See Attachment 4)
Iowa Health Solutions (See Attachment 5)
Wellmark Blue Cross Blue Shield of Iowa (See Attachment 6)

6.1.3. ☐ Existing Comprehensive State-Based Coverage; **(Section 2103(a)(3) and 42 CFR 457.440)** [Only applicable to New York; Florida; Pennsylvania] Please attach a description of the benefits package, administration, date of enactment. If existing comprehensive state-based coverage is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for a existing comprehensive state-based coverage.

6.1.4. ☐ Secretary-Approved Coverage. **(Section 2103(a)(4)) (42 CFR 457.450)**

6.1.4.1. ☐ Coverage the same as Medicaid State plan

6.1.4.2. ☐ Comprehensive coverage for children under a Medicaid Section 1115 demonstration project

6.1.4.3. ☐ Coverage that either includes the full EPSDT benefit or that the state has extended to the entire Medicaid population

6.1.4.4. ☐ Coverage that includes benchmark coverage plus additional coverage

6.1.4.5. ☐ Coverage that is the same as defined by existing comprehensive state-based coverage.

6.1.4.6. ☐ Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit by benefit comparison (Please provide a sample of how the comparison will be done)

6.1.4.7. ☐ Other (Describe)

6.2. The state elects to provide the following forms of coverage to children: (Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) **(Section 2110(a)) (42CFR 457.490)**

6.2.1. X Inpatient services **(Section 2110(a)(1))**

6.2.2. X Outpatient services **(Section 2110(a)(2))**

6.2.3. X Physician services **(Section 2110(a)(3))**

6.2.4. X Surgical services **(Section 2110(a)(4))**

6.2.5. X Clinic services (including health center services) and other ambulatory health care services. **(Section 2110(a)(5))**

6.2.6. X Prescription drugs **(Section 2110(a)(6))**

6.2.7. ☐ Over-the-counter medications **(Section 2110(a)(7))**

6.2.8. X Laboratory and radiological services **(Section 2110(a)(8))**

6.2.9. X Prenatal care and prepregnancy family services and supplies **(Section 2110(a)(9))**

6.2.10. X Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services **(Section 2110(a)(10))**

6.2.11. X Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services **(Section 2110(a)(11)**

6.2.12. X Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) **(Section 2110(a)(12))**

6.2.13. ☐ Disposable medical supplies **(Section 2110(a)(13))**

6.2.14. ☐ Home and community-based health care services (See instructions) **(Section 2110(a)(14))**

6.2.15. X Nursing care services (See instructions) **(Section 2110(a)(15))**

6.2.16. X Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest **(Section 2110(a)(16)**

6.2.17. X Dental services **(Section 2110(a)(17))**

6.2.18. X Inpatient substance abuse treatment services and residential substance abuse treatment services **(Section 2110(a)(18))**

6.2.19. X Outpatient substance abuse treatment services **(Section 2110(a)(19))**

6.2.20. X Case management services **(Section 2110(a)(20))**

6.2.21. ☐ Care coordination services **(Section 2110(a)(21))**

6.2.22. X Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders **(Section 2110(a)(22))**

6.2.23. X Hospice care **(Section 2110(a)(23))**

6.2.24. X Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) **(Section 2110(a)(24))**

6.2.25. ☐ Premiums for private health care insurance coverage **(Section 2110(a)(25))**

6.2.26. X Medical transportation **(Section 2110(a)(26))**

6.2.27. ☐ Enabling services (such as transportation, translation, and outreach services (See instructions) **(Section 2110(a)(27))**

6.2.28. ☐ Any other health care services or items specified by the Secretary and not included under this section **(Section 2110(a)(28))**

6.3 The state assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan: **(42CFR 457.480)**

6.3.1. X The state shall not permit the imposition of any pre-existing medical condition exclusion for covered services **(Section 2102(b)(1)(B)(ii))**; **OR**

6.3.2. ☐ The state contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.4.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA **(Section 2103(f))**. Please describe: *Previously 8.6*

6.4 **Additional Purchase Options.** If the state wishes to provide services under the plan through cost effective alternatives or the purchase of family coverage, it must request the appropriate option. To be approved, the state must address the following: **(Section 2105(c)(2) and(3)) (42 CFR 457.1005 and 457.1010)**

6.4.1. ☐ **Cost Effective Coverage.** Payment may be made to a state in excess of the 10% limitation on use of funds for payments for: 1) other child health assistance for targeted low-income children; 2) expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); 3) expenditures for outreach activities as provided in section 2102(c)(1) under the plan; and 4) other reasonable costs incurred by the state to administer the plan, if it demonstrates the following **(42CFR 457.1005(a)):**

6.4.1.1. Coverage provided to targeted low-income children through such expenditures must meet the coverage requirements above; **Describe the coverage provided by the alternative delivery system. The state may cross reference section 6.2.1 - 6.2.28. (Section 2105(c)(2)(B)(i)) (42CFR 457.1005(b))**

6.4.1.2. The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above.; **Describe the cost of such coverage on an average per child basis**. **(Section 2105(c)(2)(B)(ii)) (42CFR 457.1005(b))**

6.4.1.3. The coverage must be provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section 1886(c)(5)(F) or 1923 of the Social Security Act. **Describe the community based delivery system. (Section 2105(c)(2)(B)(iii)) (42CFR 457.1005(a))**

6.4.2. ☐ **Purchase of Family Coverage.** Describe the plan to purchase family coverage. Payment may be made to a state for the purpose of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children, if it demonstrates the following: **(Section 2105(c)(3)) (42CFR 457.1010)**

6.4.2.1. Purchase of family coverage is cost-effective relative to the amounts that the state would have paid to obtain comparable coverage only of the targeted low-income children involved; and **(Describe the associated costs for purchasing the family coverage relative to the coverage for the low income children.)** **(Section 2105(c)(3)(A)) (42CFR 457.1010(a))**

6.4.2.2. The state assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. **(Section 2105(c)(3)(B)) (42CFR 457.1010(b))**

6.4.2.3. The state assures that the coverage for the family otherwise meets title XXI requirements. **(42CFR 457.1010(c))**

Section 7. Quality and Appropriateness of Care

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state Medicaid plan**, and continue on to Section 8.

7.1. Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. **(2102(a)(7)(A)) (42CFR 457.495(a))**

Will the state utilize any of the following tools to assure quality?
(Check all that apply and describe the activities for any categories utilized.)

7.1.1. X Quality standards

The Department of Human Services (DHS) encourages all contracted managed health plans to pursue National Committee for Quality Assurance (NCQA) or Joint Commission on Accreditation of Healthcare Organizations (JCAHO) certification.

DHS contracts with the Iowa Foundation for Medical Care (IFMC) to conduct external quality reviews onsite (EQRO) evaluations at contracted ***hawk-***i medical health plans annually. The purpose of the onsite evaluation is to assure that each contracted plan is providing quality and accessible services for ***hawk-***i members.

The IFMC Evaluation Team includes licensed IFMC staff and a minimum of one practicing physician. Team members are experienced in managed care peer-to-peer review, quality improvement principles, and performance measurement.

The Team uses an IFMC-developed and DHS approved administrative tool to evaluate the plan's activities in the following areas:

1) Internal Quality Management and Improvement,
2) Utilization Management,
3) Credentialing and Recredentialing,
4) Member Rights and Responsibilities,
5) Disease Prevention and Health Promotion Services, and
6) Access

Each broad area contains individual components. Some areas include subcategories with individual components. The components in each of the seven categories were developed based on NCQA requirements, Federal legislation; Guide to Clinical Preventive Services, Report of the U.S. Preventive services Task Force, Second Edition; Center for

Disease Control Prevention Guidelines; nationally accepted practice standards; and/or managed care organization commercial contract requirements.

7.1.2. X Performance measurement
Refer to Section 9.1

The ***hawk-i*** Functional Health Assessment Survey
The report presents the results of an ongoing evaluation of the impact of the Healthy and Well Kids in Iowa (***hawk-i***) Program on the access to and health status of enrolled children. The first evaluation, parents' responses to a survey given at the time they joined the program (the baseline survey) are compared with their responses to a survey given after their child has been enrolled for about a year (the follow-up survey) to determine if there are differences in the perceived ability to receive health services or in their child's health status. Also included in the follow-up survey and presented in the report are questions specific to ***hawk-i*** , such as ratings of the private health plans that contract with ***hawk-i*** and the impact of having health insurance.

7.1.3. X Information strategies
All health plans participating in the ***hawk-i*** program are required to provide encounter data in accordance with the provisions outlined in their contract.

Additionally, all health plans are required to provide written information to enrollees which, at a minimum, includes the following:

- the phone number(s) that can be used for assistance to obtain information about emergency care, prior authorization, scheduling appointments, and standard benefit/services information;
- current provider directory;
- hours of service of the plan;
- appeal procedures;
- policies on the use of emergency services
- information on the use of non-participating providers;
- access of after hours care;
- enrollee rights and responsibilities;
- procedures for notifying enrollees of changes in the benefits or delivery of services; and
- procedures for recommending changes in polices and procedures.

7.1.4. X Quality improvement strategies
All health plans participating in the ***hawk-i*** program are required to have quality improvement plans in place, including mechanisms that

allow enrollees to provide input as to how the delivery of services and other aspects of the plan could be improved.

The Department and the ***hawk-***i Board created a Quality Assessment and Improvement Committee. The Committee meets quarterly to review data, reports and medical audit results. The committee makes recommendations to the ***hawk-i*** Board on program quality standards and improvement strategies. The nine-member committee is comprised of community medical professionals representing pediatricians, family practice, dental, mental health, nutrition and pharmacy.

Refer to 7.1.1 for explanation of EQRO component.

7.2. Describe the methods used, including monitoring, to assure: **(2102(a)(7)(B)) (42CFR 457.495)**

7.2.1 Access to well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations. **(Section 2102(a)(7)) (42CFR 457.495(a))**

All health plans are contractually required to provide well-baby care, well-child care, well adolescent care and childhood and adolescent immunization services.

All participating health plans send reminder notices to families that their child(ren) is due for immunizations or well child visits. Additionally, newsletters are sent to families educating them about the importance of preventative services.

The ***hawk-i*** Program collects encounter claims data from participating health plans monthly. HEDIS performance measurements for well-child and adolescent care and immunizations have been selected for results based analysis (see 9.1).

In conjunction with the performance based claims analysis, ***hawk-i*** examines quality, appropriateness, and access to care through IFMC EQRO (see 7.1.1). As part of the review, well-baby care reports, encounter data, and immunizations rates are analyzed following the American Academy of Pediatrics guidelines to assure adequate delivery of health care to enrolled children. In conjunction with the EQRO annual on-site visit, a medical record review that retrospectively compares claims to medical records are randomly selected for well-child and immunization services is done.

hawk-i 's Functional Health Assessment Survey is an excellent tool to evaluate health status of children enrolled in the ***hawk-i*** program.

7.2.2 Access to covered services, including emergency services as defined in 42 CFR §457.10. **(Section 2102(a)(7)) 42CFR 457.495(b))**

DHS examines access to care through the IFMC EQRO contract (see 71.1). Additionally, DHS uses Geographic Information Systems (GIS) maps to examine the distribution of primary care, dental, and mental health providers for each participating health plan at the county level of geography. The map tracks the geographical distribution of providers in comparison to the number of beneficiaries served in a particular coverage area as well as the distance and time to get to the provider. Access standards utilized for the GIS are 30 minutes/30 miles for primary care provider and dental services, 60 minutes/60 miles for specialty services including mental health and substance abuse.

As noted above, health plans are contractually required to include written procedures in the member handbook on accessing emergency services.

Contracted health plans are required to submit complaint/grievance reports to the Department on a quarterly basis. Additionally, assessment surveys ask specific questions about the member's satisfaction with emergency services.

7.2.3 Appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee'□ medical condition. **(Section 2102(a)(7)) (42CFR 457.495(c))**

Contractually, health plans are required to ensure patient care that is coordinated and continuous, including at a minimum:

- systems to assure timely and appropriate referrals for Medically Necessary, specialty, secondary and tertiary care including subspecialization for pediatric care as well as health education services for members; and
- systems to assure provision of care in situations requiring treatment for an emergency medical condition, including an education process to help assure that members know where and how to obtain medically necessary care in an emergency.
- systems to assure that the plan shall not limit providers from disclosing all information about services available to the member related to their medical condition irrespective of the plans coverage or provider network.

Iowa House File (HF2517), the bill that created the ***hawk-i*** program, mandated that a Special Needs Committee be established to make recommendations to the board and to the general assembly concerning the provision of health

insurance coverage to children with special health care needs under the program. The purpose of the Committee is to address the following:

1) Define the target population of children with special health care needs for the purposes of determining eligibility under the program.
2) Eligibility options for and assessment of children with special health care needs for eligibility.
3) Benefit options for children with special health care needs.
4) The appropriateness and quality of care for children with special health care needs.
5) Coordination of health services provided for children with special health care needs under the program with services provided by other publicly funded programs.

The Special Needs Committee has periodic meetings with contracted health plans to discuss case management services for members with long-term health care needs.

The Functional Health Assessment Survey asks questions related specifically to a child with chronic medical conditions (see 7.1.2).

The State examines care provided to chronic and special need populations including access to care through the IFMC EQRO contract (see 7.1.1).

7.2.4 Decisions related to the prior authorization of health services are completed in accordance with state law **or,** in accordance with the medical needs of the patient, within 14 days after the receipt of a request for services. **(Section 2102(a)(7)) (42CFR 457.495(d))**

The following language is included in all health plan contracts follows: "If the Plan has Prior Authorization of health services, in accordance with the medical needs of the patient, the Plan shall complete the Prior authorization within fourteen (14) days after receipt of a request for services. An extension of up to fourteen (14) days may be permitted if the Enrollee requests the extension or if the physician or Plan determines that additional information is needed. "

The State examines prior authorization compliance through the IFMC EQRO contract (see 71.1).

Section 8. Cost Sharing and Payment (Section 2103(e))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state Medicaid plan**, and continue on to Section 9.

8.1. Is cost-sharing imposed on any of the children covered under the plan? **(42CFR 457.505)**

8.1.1. X YES

8.1.2. ☐ NO**, skip to question 8.8.**

8.2. Describe the amount of cost-sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge and the service for which the charge is imposed or time period for the charge, as appropriate.
(Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) &(c), 457.515(a)&(c))

8.2.1. Premiums: $10 per child per month, with a maximum of $20 per family for families whose countable income is equal to or greater than 150% of the FPL. Premiums are not imposed on Native American, Alaskan Native children regardless of family income. If a family reports a decrease in income anytime during the 12-month eligibility period and the new income is less than 150% of the FPL, the family does not pay a premium for the reminder of the eligibility period.

8.2.2. Deductibles: None

8.2.3. Coinsurance or copayments: Families whose countable income is equal to or greater than 150% of the FPL shall be assessed a $25 copayment for each emergency room visit if the child's medical condition does not meet the definition of emergency medical condition. Copayments are not assessed for Native American, Alaskan Native children, regardless of income. An emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent lay person, who possess an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following:

1. Placing the health of the person or, with respect to a pregnant woman, the health of the

woman and her unborn child, in serious jeopardy,
2. Serious impairment to bodily functions or,
3. Serious dysfunction of any bodily organ or part.

8.2.4. Other:

8.3. Describe how the public will be notified, including the public schedule, of this cost-sharing (including the cumulative maximum) and changes to these amounts and any differences based on income. **(Section 2103(e)((1)(B)) (42CFR 457.505(b))**

Cost sharing is described in the Iowa Administrative Rules and in printed materials about the program, including the informational brochure that contains the application form. (See Attachment 7) Additionally, when approved, each family will receive an approval notice that lists their countable income calculation and the amount of cost sharing, if any.

8.4. The state assures that it has made the following findings with respect to the cost sharing in its plan: **(Section 2103(e))**

8.4.1. X Cost-sharing does not favor children from higher income families over lower income families. **(Section 2103(e)(1)(B)) (42CFR 457.530)**

8.4.2. X No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. **(Section 2103(e)(2)) (42CFR 457.520)**

8.4.3 X No additional cost-sharing applies to the costs of emergency medical services delivered outside the network. **(Section 2103(e)(1)(A)) (42CFR 457.515(f))**

8.5. Describe how the state will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family's income for the length of the child's eligibility period in the State. Include a description of the procedures that do not primarily rely on a refund given by the state for overpayment by an enrollee: **(Section 2103(e)(3)(B)) (42CFR 457.560(b) and 457.505(e))**

There are only two forms of cost sharing in the ***hawk-i*** program. In both cases, they apply only to families with income that equals or exceed 150% of FPL.
1. Premiums of $10 ($120 annually) per child per month with a family maximum of $20 ($240) annually; and
2. A $25 copayment for inappropriate use of the emergency room.

At current poverty levels, the family would have to incur the number of inappropriate emergency room visits indicated below to exceed 5%. Health plans will report enrollee ER usage, resulting in a copayment obligation, to the third party administrator. The third party administrator will track the ER copayment to ensure

cost sharing does not exceed 5% of the family income. At the point the ER copayment results in cost sharing exceeding 5%, enrollees will be reimbursed for the cost.

It is expected that the health plans will intervene to educate enrollees about the appropriate use of ER services prior to any family utilizing the ER inappropriately in as many instances indicated in the chart.

HH Size	Annual Income at 150% FPL	5%	Premium Maximum		No. of Annual Inappropriate ER Visits
1	$13,290	$ 664.50	$120	($544.50/$25)	22
2	$17,910	$ 895.50	$240	($655.50/$25)	26
3	$22,530	$1,126.50	$240	($886.50/$25)	35
4	$27,150	$1,357.50	$240	($1117.50/$25)	45
5	$31,770	$1,588.50	$240	($1348.50/$25)	54
6	$36,390	$1,819.50	$240	($1579.50/$25)	63
7	$41,010	$2,050.50	$240	($1810.50/$25)	72
8	$45,630	$2,281.50	$240	(2041.50/$25)	82

8.6 Describe the procedures the state will use to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost sharing. **(Section 2103(b)(3)(D)) (42CFR 457.535)**

The brochure that contains the ***hawk-i*** application states that there is no cost sharing for American Indian/Alaskan Native children. At the time the applicant is approved for the ***hawk-i*** program, an approval notice is sent indicating there is no cost sharing. These provisions are also found in the Iowa Administrative Code at 441- 86.8(1).

Applications to the ***hawk-i*** program ask for the race of the children applying. When race is indicated as Native American or Alaska Native, no cost sharing is assessed to American Indian or Alaska Native children, regardless of income.

8.7 Please provide a description of the consequences for an enrollee or applicant who does not pay a charge. **(42CFR 457.570 and 457.505(c))**

When an applicant receives notification that the applicant is eligible to participate in the program and a premium is required, the applicant has ten working days from the notification to pay the premium. No premium shall be assessed for months of coverage prior to, and including the month of decision. If the premium is not received by the tenth working day, the applicant is sent a notice of denial of eligibility. The applicant has the right to appeal this decision.

After the initial month of coverage, the premium is due no later than the last day of the month prior to the month of coverage. Failure to pay the premium by the last day of the month before the month shall result in cancellation from the program and disenrollment from the health plan.

A child may be reinstated once in a 12-month period when the family fails to pay the premium by the last day of the month prior to the month of coverage. However, the reinstatement must occur within the calendar month following the month of nonpayment and the premium must be paid in full prior to reinstatement. Once a child is disenrolled and canceled from the program due to nonpayment of premiums, the family must reapply for coverage.

If a family reports a decrease in income and a premium is no longer required, premiums will no longer be charged beginning with the month following the month of the report of the change.

Any time an adverse action is taken such as disenrollment and cancellation from the program, the enrollee has the right to appeal the decision. The appeal rights and procedures are written on the backside of the notice.

8.7.1 Please provide an assurance that the following disenrollment protections are being applied:

- X State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment. **(42CFR 457.570(a))**
- X The disenrollment process affords the enrollee an opportunity to show that the enrollee family income has declined prior to disenrollment for non payment of cost-sharing charges. **(42CFR 457.570(b))**
- X In the instance mentioned above, that the state will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. **(42CFR 457.570(b))**
- X The state provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. **(42CFR 457.570(c))**

8.8 The state assures that it has made the following findings with respect to the payment aspects of its plan: **(Section 2103(e))**

8.8.1. X No Federal funds will be used toward state matching requirements. **(Section 2105(c)(4)) (42CFR 457.220)**

8.8.2. X No cost-sharing (including premiums, deductibles, copays, coinsurance and all other types) will be used toward state matching requirements. **(Section 2105(c)(5) (42CFR 457.224)** (*Previously 8.4.5)*

8.8.3. X No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title. **(Section 2105(c)(6)(A)) 42CFR 457.626(a)(1))**

8.8.4. X Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. **(Section 2105(d)(1)) (42CFR 457.622(b)(5))**

8.8.5. X No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. **(Section 2105)(c)(7)(B)) (42CFR 457.475)**

8.8.6. X No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). **(Section 2105)(c)(7)(A)) (42CFR 457.475)**

Section 9. Strategic Objectives and Performance Goals and Plan Administration (Section 2107)

9.1. Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children: **(Section 2107(a)(2)) (42CFR 457.710(b))**

Objective One: Increase the health status of children in Iowa.

Objective Two: Increase the number of children who have access to health care.

Objective Three: Reduce the instances of hospitalization for medical conditions that can be treated with routine care (e.g. asthma).

Objective Four: Reduce the instances of emergency room visits for treatment of a medical condition that could be treated in another medical setting.

Objective Five: All children participating in the program will have a medical home.

9.2. Specify one or more performance goals for each strategic objective identified: **(Section 2107(a)(3)) (42CFR 457.710(c))**

Objective One: Increase the health status of children in Iowa.

Medicaid Expansion health status goals:

- Enroll approximately 15,600 additional children in the Medicaid expansion program.
- Enrollment goal for June 30, 2003 is 10,676.
- Health status and health care system measures will show acceptable incremental improvements for the following outcome measurements:

1. Seventy-five percent of enrolled children will be appropriately immunized at age two excluding varicella immunizations. A baseline rate for comparison for varicella will be established by a clinical advisory committee.
2. Eighty percent of enrolled children will participate in EPSDT and receive a well-child visit, as measured by the HCFA 416 (Annual EPSDT Participation Report)
3. Eighty percent of enrolled children will have received at least one preventive dental visit annually.

Healthy and Well Kids in Iowa (***hawk-i***):

- Enroll an estimated 39,500 children into health plans participating in the ***hawk-i*** program.

1. Enrollment goal for June 30, 2003 is 21,403.
2. By January 1, 2003, the following health status and health care system measures will have established benchmarks for the following;
    a) Children who turn two enrolled in the measurement year, who are continuously enrolled for 12 months immediately preceding their second birthday, will be appropriately immunized with one MMR, by the member's second birthday.
    b) Children 2 and 3 years old who were continuously enrolled during the measurement year, will have at least one annual dental visit during the measurement year.
    c) Children ages 3- 6 and adolescents who were continuously enrolled during the measurement year, will have received one or more well-child visit(s) or well-adolescent visit(s) with a primary care practitioner during the measurement year.
    d) The number and percentage of members receiving mental health services during the measurement year in the following categories: Any mental health services (inpatient, day/night, ambulatory), Inpatient mental health services, Day/Night mental health services and ambulatory mental health services. This information is reported by age and sex. This measure is intended to give an overview of the extent to which the health plan uses the different levels of mental health care.
    e) Send each family a health assessment questionnaire to complete for one child in the household. (Refer to Attachment 8).

Objective Two: Increase the number of children who have access to health care.

- Continue increased growth through strengthening grass roots outreach efforts, training and collaboration with other agencies/groups as the budget allows. The focus is to develop an infrastructure to support and communicate with

ever-changing personnel at three levels: the third party administrator, the grass roots outreach network, and the partnering agencies. The infrastructure including on-going communication, training on request, consistent reporting and feedback, and monitoring individual cases to identify and address trends.

- Support the various outreach efforts through media advertising, TV and radio commercials, promoting the ***hawk-***i program in English and Spanish as the budget allows.

Objective Three: Reduce the instances of hospitalization for medical conditions that can be treated with routine care (e.g. asthma).

Medicaid Expansion

- Percent of children admitted as inpatients for asthma.

Objective Four: Reduce the instances of emergency room visits for treatment of a medical condition that could be treated in another medical setting (e.g. otitis media).

Medicaid Expansion and Healthy And Well Kids In Iowa (***hawk-i***)

- Reduce the number of emergency room visits for treatment of non-emergent medical conditions.

Objective Five: All children participating in the program will have a medical home. (Note: this objective does not apply to those children enrolled in the non-Medicaid program in counties in which only an indemnity plan is available under ***hawk-i***).

- At least 50% of those children enrolled (except those exempted from participation in managed care such as children in foster care) will have a medical home as evidenced by documented assignment of a provider through the MediPASS program or a Medicaid HMO. (Medicaid expansion only)

9.3. Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the state's performance, taking into account suggested performance indicators as specified below or other indicators the state develops:
(Section 2107(a)(4)(A),(B)) (42CFR 457.710(d))

Assurance of an Objective Means for Measuring Performance

Iowa will measure performance by establishing a baseline for each performance goal through various methods including: conducting a baseline population-based survey; using State vital records, hospital discharge and claims information; and using other Medicaid and non-Medicaid data bases that provide relevant information. For each performance goal, the method of measurement will be established and reports will be generated to monitor, on an ongoing basis, Iowa's progress toward meeting the goal.

Objective One: Increase the health status of children in Iowa.

Measurement of Performance:

- Every family approved for the ***hawk-i*** program will be asked to complete a health assessment questionnaire for one child in the household. (Refer to Attachment 8). The State has contracted with the University of Iowa to analyze the results of the survey, both at the initial submission and the next review (12 months) when the family is asked to complete the survey on their past 12 month's experience.
- Survey outcomes include:
  1) Access to care (unmet need) and regular source of medical care,
  2) ER use,
  3) Unmet need and regular source of dental care,
  4) Unmet need for vision care, pharmacy, and behavioral/emotional care,
  5) Receipt of anticipatory guidance
  6) Child's health status
  7) Family environment (e.g., stress)
- Training - Documentation that 100% of eligibility workers, administrative staff and outreach/case managers responsible for any aspect of implementation of the program, receive ongoing training regarding the program and their implementation responsibilities.
- Publications/Documents - 100% of program manuals and literature for program personnel, literature for consumers and literature for providers contain up-to-date information (as appropriate to the document) regarding the program, its rules and regulations, and pertinent departmental policies; are written at appropriate grade levels; and will reach potential eligibles and providers.

- Number of middle and older adolescents, aged 14-18 years during the reporting period who had at least one EPSDT, comprehensive well-child visit with a primary care provider during the reporting year.(Medicaid Expansion)
- Number of 3 to 6 and adolescents who received one or more well child/adolescent visit with a primary care practitioner during the reporting year. (HEDIS**)** (***hawk-i*** program)
- Number of children who had at least one preventive dental visit during the reporting year.-(HEDIS) (Medicaid Expansion and ***hawk-i*** program)
- Number of children under age two who are appropriately immunized. (Medicaid Expansion)
- Number of children who turn two will be immunized with one MMR (HEDIS) (***hawk-i*** program)
- Number of members receiving mental health services during the reporting year. (HEDIS) (***hawk-i*** program)

Objective Two: Increase the number of children who have access to health care.

Measurement of Performance:

- Outreach identification of Medicaid-eligible children - At least 15,000 children will be assessed for eligibility in Iowa's expanded Medicaid program.
- Insurance Coverage/Expansion of coverage Provision of Medicaid coverage to previously uncovered children - At least 10,000 previously uninsured, low-income children will be enrolled in Iowa- expanded Medicaid program by June of 2003.
- Healthy And Well Kids in Iowa (***hawk-i***) Program. As of June 30, 2003, 21,403 previously uncovered children will be enrolled in ***hawk-i***.

Objective Three: Reduce the number of hospitalizations for medical conditions that can be treated with good quality primary care (e.g. asthma).

Measurement of Performance

- The number of hospital admissions with a primary diagnosis of asthma is compiled via claims data and reported through the data decision support system. Annually data is compiled and compared to the previous year.

Objective Four: Reduce the instances of emergency room visits for treatment of a medical condition that could be treated in another medical setting (e.g. otitis media).

Measurement of Performance

- Annually a "Consumer Assessment" report is published by the University of Iowa Public Policy Center. Medicaid (Medicaid Expansion) and *hawk-i* enrollees are asked to complete a survey utilizing a hybrid CAHPS survey instrument. One of the questions asked on the survey is if the enrollee received emergency room services in the past six months. Results of the annual survey are compared to prior year findings. The report measures the percentage of children that utilized emergency room services. The goal is to reduce the percentage of children that utilize emergency room services in future years.

Objective Five: All children participating in the program will have a medical home. (Note: this objective does not apply to those children enrolled in the non-Medicaid program in counties in which only an indemnity plan is available under ***hawk-i***)

Measurement of Performance

- One primary medical provider (or provider site) for each enrollee. Documentation of assignment of a primary medical provider to each child enrolled in Medicaid Expansion of the program and those enrolled in managed care plans in ***hawk-i.***

Check the applicable suggested performance measurements listed below that the state plans to use: **(Section 2107(a)(4))**

9.3.1. X The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.
9.3.2. X The reduction in the percentage of uninsured children.
9.3.3. X The increase in the percentage of children with a usual source of care.
9.3.4. X The extent to which outcome measures show progress on one or more of the health problems identified by the state.
9.3.5. X HEDIS Measurement Set relevant to children and adolescents younger than 19.
9.3.6. X Other child appropriate measurement set. List or describe the set used.
9.3.7. X If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:
  9.3.7.1. X Immunizations
  9.3.7.2. X Well child care
  9.3.7.3. X Adolescent well visits
  9.3.7.4. X Satisfaction with care
  9.3.7.5. X Mental health

9.3.7.6. X Dental care

9.3.7.7. ☐ Other, please list:

9.3.8. X Performance measures for special targeted populations. (asthma and diabetes)

9.4. X The state assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. **(Section 2107(b)(1)) (42CFR 457.720)**

9.5. X The state assures it will comply with the annual assessment and evaluation required under Section 10. Briefly describe the state's plan for these annual assessments and reports. **(Section 2107(b)(2)) (42CFR 457.750)**

Iowa's SCHIP annual report is completed by January 1 following the end of the Federal fiscal year utilizing the framework template developed by the National Academy for State Health Policy (NASHP).

The March supplement to the Current Population Survey (CPS) is utilized to calculate the baseline number of uncovered low-in children in Iowa.

The State has an approved Section 1915(b) waiver for Primary Care Case Management (PCCM). The State is responsible for assessment and evaluation under the PCCM waiver and intends to use the same investigator and contract for his Medicaid expansion as used for the PCCM. The investigator (the Public Policy Center at the University of Iowa) will have access to Medicaid data and can develop measures such as number of office visits, continuity of care, and hospitalizations that would compare the newly enrolled group to the currently existing Medicaid population.

9.6. X The state assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit. **(Section 2107(b)(3)) (42CFR 457.720)**

9.7. X The state assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed. **(42CFR 457.710(e))**

9.8. X The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: **(Section 2107(e)) (42CFR 457.135)**

9.8.1. X Section 1902(a)(4)(C) (relating to conflict of interest standards)
9.8.2. X Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)
9.8.3. X Section 1903(w) (relating to limitations on provider donations and taxes)
9.8.4. X Section 1132 (relating to periods within which claims must be filed)

9.9. Describe the process used by the state to accomplish involvement of the public in the design and implementation of the plan and the method for insuring ongoing public involvement. **(Section 2107(c)) (42CFR 457.120(a) and (b))**

The initial implementation of ***hawk-i*** included public involvement through an appointed task force, public forums and the creation of the ***hawk-i*** Board (see 1.3). Rural and urban focus groups were also held to obtain input into the application and outreach materials.

There are two venues by which the public can provide input into any changes made in the ***hawk-i*** program:

1) The ***hawk-i*** Board meetings are held monthly and are open to the public. The agenda for the Board meeting is posted on the ***hawk-i*** website prior to the meeting. During each meeting time is allowed for public comment on any changes being proposed or any aspect of the program; or
2) Through the administrative rules process. The Administrative Procedures Act, Iowa Code Chapter 17A, requires all state agencies to promulgate rules for the operation of their programs. The rule-making process increases agencies' accountability to the public, allows public participation in the formulation of rules, and provides legislative oversight for program operations.

Before the Department's rules are adopted, they are published in the Iowa Administrative Bulletin as a "notice of intended action." Any interested people may submit comments on the proposed rules within time frames set forth in the notice. All notices must allow at least 20 days for persons to submit comments or to request an oral presentation.

The Department may not adopt the rules until 35 days after the date the notice of intended action is published. Following notice and adoption, the final rules are again published in the Iowa Administrative Bulletin. They become effective at a date specified with the final rule. Normally the Department must allow at least 35 days from the date of publication for people to prepare to implement the rules.

The ***hawk-i*** Board first approves any proposed changes to the ***hawk-i*** administrative rules during public meetings. The rules then go through the Department's administrative rules process. The ***hawk-i*** Board must then approve the rules for a second time during a public meeting before they are adopted.

9.9.1 Describe the process used by the state to ensure interaction with Indian Tribes and organizations in the state on the development and implementation of the procedures required in 42 CFR §457.125. **(Section 2107(c)) (42CFR 457.120(c))**

The state will send a copy of any proposed rule for the ***hawk-i*** program to the Native American Tribes for review and comment.

Contracts with local grassroots organizations require that the action plan for local outreach activities must how the contractor will engage the special populations in their area, including but not limited to, Native American tribes for development of the action plan and concurrent activities..

9.9.2 For an amendment relating to eligibility or benefits (including cost sharing and enrollment procedures), please describe how and when prior public notice was provided as required in §457.65(b) through (d).

See the response for 9.9.

9.10. Provide a one year projected budget. A suggested financial form for the budget is attached. The budget must describe: **(Section 2107(d)) (42CFR 457.140)**

- Planned use of funds, including --
  - Projected amount to be spent on health services;
  - Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
  - Assumptions on which the budget is based, including cost per child and expected enrollment.
- Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.

CHIP State Plan Amendment

SFY 2003	State Dollars	Federal Dollars	Total Dollars
Medicaid expansion	$ 5,055,562.78	$14,731,376	$ 19,786,938
HAWK-I premiums (Net of deductions for cost sharing)	$ 6,547,232.87	$19,077,945	$ 25,625,178
Administrative Costs			
Fiscal agent cost of processing Medicaid claims	$ 101,033.39	$ 294,401	$ 395,434
Outreach	$ 127,750	$ 372,250	$ 500,000
Administration	$ 484,395.55	$ 1,411,477	$ 1,895,873
Total CHIP SFY 2003	$ 12,315,975	$35,887,448	$ 48,203,423
	Administration Percent:		5.791%

Assumptions

	FY2003
Monthly average enrollment - Medicaid expansion	9,129
Monthly average enrollment - Medicaid expansion (MAC) infants	311
Monthly average enrollment - HAWK-I managed care	9,065
Monthly average enrollment - HAWK-I indemnity	7,074

		State $	Federal $	Total $
HAWK-I cost sharing	FY 2003	$(149,153)	$(434,616.02)	$ (583,769)

This has been deducted against premiums on summary page

PM/PM Rates	FY 2003
Medicaid expansion	$165.47
Medicaid expansion - (MAC) infants	$444.81
HAWK-I managed care	$119.30
HAWK-I indemnity	$155.87

Section 10. Annual Reports and Evaluations (Section 2108)

10.1. Annual Reports. The state assures that it will assess the operation of the state plan under this Title in each fiscal year, including: **(Section 2108(a)(1),(2)) (42CFR 457.750)**

10.1.1. X The progress made in reducing the number of uncovered low-income children and report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment, and

10.2. X The state assures it will comply with future reporting requirements as they are developed. **(42CFR 457.710(e))**

10.3. X The state assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.

Section 11. Program Integrity (Section 2101(a))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan**, and continue to Section 12.

11.1 X The state assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. **(Section 2101(a)) (42CFR 457.940(b))**

11.2. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: **(Section 2107(e)) (42CFR 457.935(b))** *The items below were moved from section 9.8. (Previously items 9.8.6. - 9.8.9)*

- 11.2.1. X 42 CFR Part 455 Subpart B (relating to disclosure of information by providers and fiscal agents)
- 11.2.2. X Section 1124 (relating to disclosure of ownership and related information)
- 11.2.3. X Section 1126 (relating to disclosure of information about certain convicted individuals)
- 11.2.4. X Section 1128A (relating to civil monetary penalties)
- 11.2.5. X Section 1128B (relating to criminal penalties for certain additional charges)
- 11.2.6. X Section 1128E (relating to the National health care fraud and abuse data collection program)

Section 12. Applicant and enrollee protections (Sections 2101(a))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state Medicaid plan**.

Eligibility and Enrollment Matters

12.1 Please describe the review process for **eligibility and enrollment** matters that complies with 42 CFR §457.1120.

The Iowa Department of Human Services uses the same appeal process for all of its programs, including Medicaid and ***hawk-i*** eligibility and enrollment. This process is detailed in Attachment 9.

Health Services Matters

12.2 Please describe the review process for **health services matters** that complies with 42 CFR §457.1120.

The state is using the Statewide Standard Review. Section 514I.2(10) of the Iowa Code requires all participating health plans to be licensed by the Iowa Division of Insurance. All ***hawk-i*** enrollees receive services from health insurance issuers subject to state health insurance law. Managed care organizations are subject to Iowa Code Chapter 514B and indemnity health insurance carriers are subject to Iowa Code Chapters 505, 514. All health services are subject to an external review as described in Iowa Code Chapter 514J.

See Attachment 10.

Premium Assistance Programs

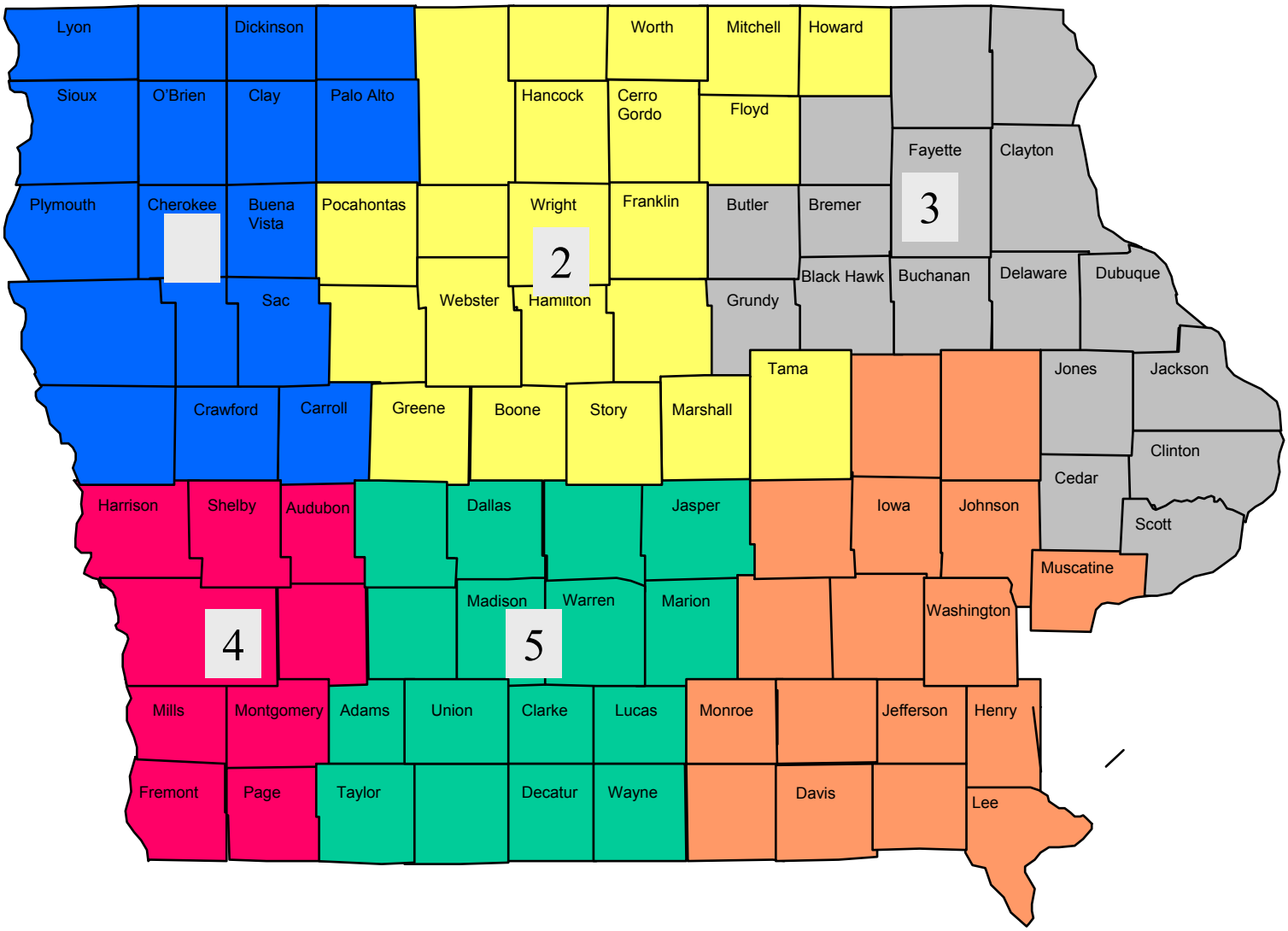
12.3 If providing coverage through a group health plan that does not meet the requirements of 42 CFR §457.1120, please describe how the state will assure that applicants and enrollees have the option to obtain health benefits coverage other than through the group health plan at initial enrollment and at each redetermination of eligibility.

Does not apply.

Attachment 1

hawk-i -regional map

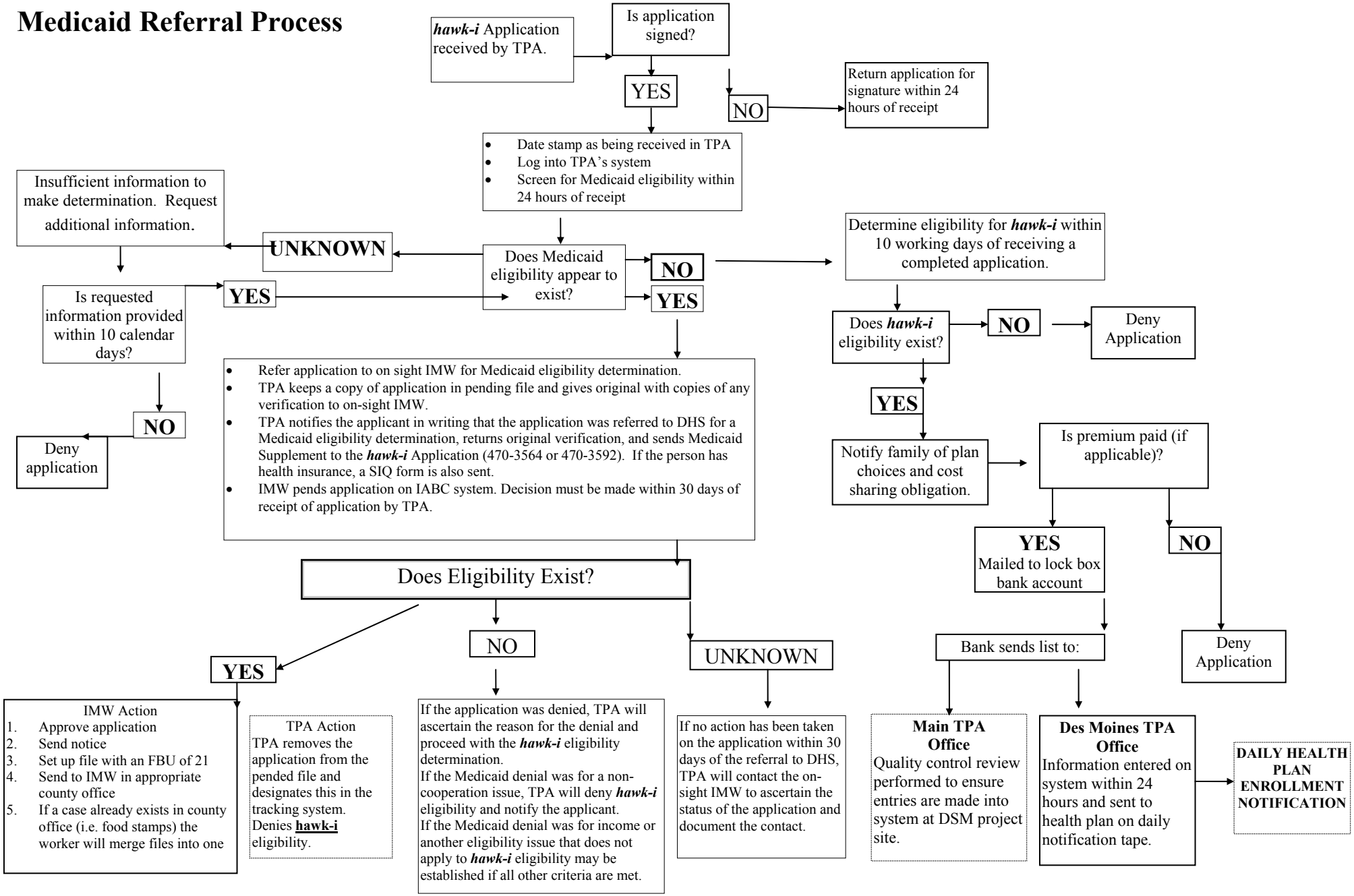
Regions for the Healthy and Well Kids in Iowa (*hawk-i*) Program



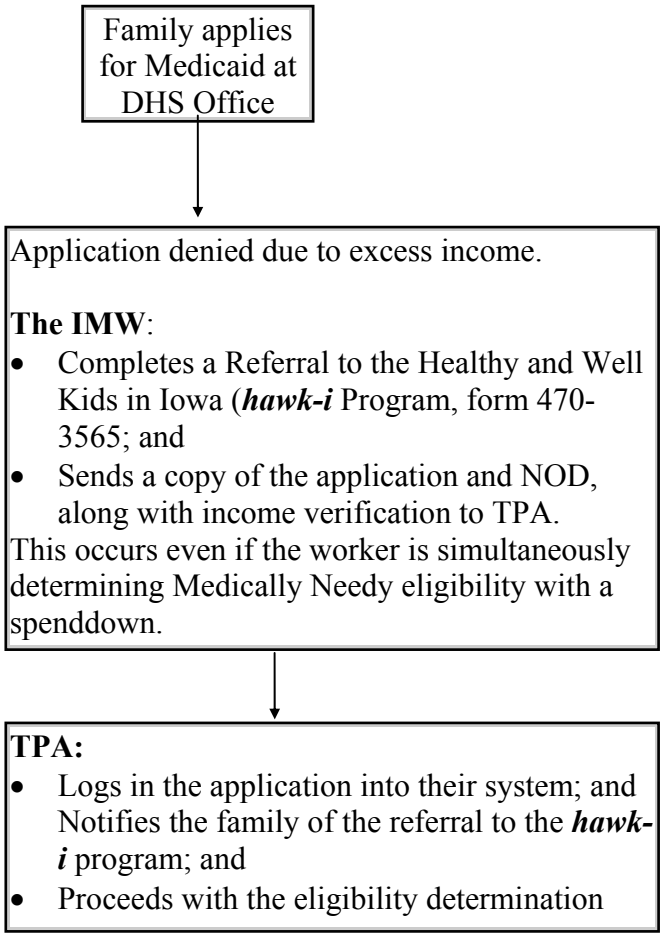
Attachment 2

Referral Process

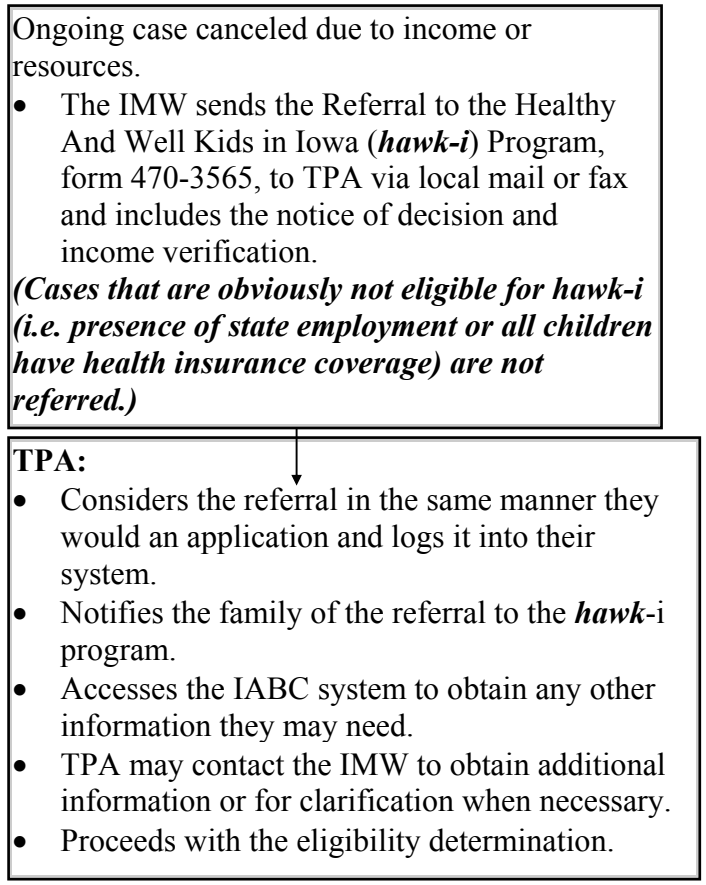
Medicaid Referral Process



DHS Referral Process to ***hawk-i***
When Medicaid Application Denied



DHS Referral Process to ***hawk-i***
When Medicaid Case Canceled



Iowa Department of Human Services

REFERRAL TO THE HEALTHY AND WELL KIDS IN IOWA (*hawk-i*) PROGRAM

Date:		Case Name:
Worker Name/Number:		Case Number:
County:	Phone:	Phone:

People in Household	Social Security Number	Birth Date	Sex	How Related to Case Name (spouse, parent, child, etc.)	Medicaid End Date	Language Preference	If child, does this child have health insurance coverage?
1.			☐ Male ☐ Female			☐ English ☐ Spanish ☐ Other:	☐Yes ☐No
2.			☐ Male ☐ Female			☐ English ☐ Spanish ☐ Other:	☐Yes ☐No
3.			☐ Male ☐ Female			☐ English ☐ Spanish ☐ Other:	☐Yes ☐No
4.			☐ Male ☐ Female			☐ English ☐ Spanish ☐ Other:	☐Yes ☐No
5.			☐ Male ☐ Female			☐ English ☐ Spanish ☐ Other:	☐Yes ☐No
6.			☐ Male ☐ Female			☐ English ☐ Spanish ☐ Other:	☐Yes ☐No
7.			☐ Male ☐ Female			☐ English ☐ Spanish ☐ Other:	☐Yes ☐No

This case is being referred to ***hawk-i*** because:

☐ The family must meet a spenddown under the Medically Needy program.

☐ Check here if the family has declined Medically Needy.

☐ Other reason for Medicaid ineligibility, specify:

☐ The following children have been voluntarily excluded from the Medicaid eligible group because the child's income creates Medicaid ineligibility for the remaining household members. (Note: Children voluntarily excluded for nonfinancial reasons are not eligible for ***hawk-i***.)

1.

2.

3.

Attachments: ☐ Income verification ☐ Copy of application ☐ Copy of notice of decision

Comments:

REMINDER - Do Not Refer Children to the *hawk-i* Program When:

- Family income (gross earnings – 20% + unearned income) exceeds 200% of the federal poverty level for a family of the same size; **or**
- A parent is a State of Iowa employee; **or**
- The children do not meet Medicaid's alienage requirements (they are the same for ***hawk-i***); **or**
- The children are over age 19; **or**
- The reason for Medicaid ineligibility is due to a non-cooperation issue.

Send via local mail to: **OR** **Fax:** 515-457-7701

Department of Human Services
Attn: MAXIMUS/***hawk-i*** Program
Division of Financial, Health and Work Supports 5th Floor
1305 E Walnut
Des Moines IA 50319-0114

hawk-i Referral Process
A Desk Guide for Income Maintenance Workers

Policy: Refer children under age 19 to the ***hawk-i*** program when any child for whom a family is applying is over income for Medicaid or is conditionally eligible for MN. (Employees' Manual Chapters 8-B & 8-G)

Making a Referral:

Referring a Denied Application	Referring a Cancelled Case
To refer an application that has been denied or an application that has been approved only for MN with a spenddown: ❑ Fill out the referral form* and send it to ***hawk-i*** with copies of: 1. the Medicaid application 2. the income verification 3. the notice of decision ❑ Make the referral within one working day from the time that you know that the child is not eligible for Medicaid or that they must meet a spenddown under Medically Needy. ❑ The Medicaid application date will become the ***hawk-i*** filing date.	To refer a case that has been cancelled or must now meet a spenddown under MN: ❑ Fill out the referral form* and send it to ***hawk-i*** with copies of: 1. the income verification 2. the notice of decision ❑ Make the referral within one working day from the time that you know that the child is not eligible for Medicaid or that they must meet a spenddown under Medically Needy. ❑ If eligible, there will be no break in coverage for children moving from Medicaid to ***hawk-i.***
The family does not have to fill out a separate ***hawk-i*** application.	

* "Referral to the Healthy and Well Kids in Iowa (***hawk-i***) Program," form 470-3565, is available in State Approved Forms on Outlook.

Send the referral and accompanying verification to: (Do not send case records or original application forms)

Interoffice Mail: Department of Human Services
Attn: MAXIMUS/***hawk-i*** Program
Division of Medical Services – 5th Floor
1305 E. Walnut
Des Moines, IA 50319-0114

OR **FAX:** 515-457-7701

*Questions? Call **hawk-i** Customer Service: 1-800-257-8563*

Helpful Hints:

- If a case goes over income because of a lump sum period of proration, but the children would otherwise be Medicaid eligible, note in the comments section of the referral form that there is a lump sum, how much it is, and when the period of proration ends.

- If a child is voluntarily excluded from Medicaid because of the child's income, refer the child to ***hawk-i***. Note in the upper right corner of the back page of the referral that the child is excluded and include their income information.

- Do not refer children to ***hawk-i*** if the child has been voluntarily excluded from Medicaid for reasons other than the child's income.

- Do not refer children to ***hawk-i*** when the reason they are not eligible for Medicaid is due to non-cooperation (e.g. failure to return review forms, failure to provide verification, etc.).

- Self-employment: ***hawk-i*** allows a deduction for depreciation of capital assets for self-employment while Medicaid does not. In this situation, include the appropriate Schedule C or F when making the referral.

- Unemployment: Medicaid looks at unemployment as a weekly benefit. ***hawk-i*** looks at the maximum benefit the person can receive and uses it to project income for the 12-month enrollment period. Include the DBRO screen front page (from IWD system) when referring these cases to ***hawk-i***. Indicate in the comments section if there is any other unearned income on the NOD so it gets used.

- When you make a referral and give the family a ***hawk-i*** brochure for informational purposes, take the application out of the brochure so they don't think they have to apply separately. This will help avoid duplicate applications being filed.

hawk-i Customer Service: 1-800-257-8563
(TDD: 1-888-422-2319)
www.hawk-i.org

Attachment 3

Benchmark Plan
(not available electronically)

Attachment 4

John Deere Health Plan
(not available electronically)

Attachment 5

Iowa Health Solutions
(not available electronically)

Attachment 6

Wellmark Blue Cross Blue Shield
(not available electronically)

Attachment 7

hawk-i Brochure
(not available electronically)

Attachment 8

Functional Health Assessment Surveys

8A
Baseline Survey
(not available electronically)

8B
Follow-up Survey
(not available electronically)

Attachment 9

Appeal Process

This chapter applies to contested case proceedings conmmc5c5ducted by or on behalf of the department.

441—7.1(17A) Definitions.

"Administrative law judge" means an employee of the department of inspections and appeals who conducts appeal hearings.

"Agency" means the Iowa department of human services, including any of its local, district, institutional, or central administrative offices.

An *"aggrieved person"* is one who meets any of the following conditions:

1. Whose claim for financial assistance, Medicaid, or services has been denied.
2. Whose application has not been acted upon with reasonable promptness.
3. Who has been notified that there will be a suspension, reduction, or discontinuation of assistance, Medicaid, or services.
4. Who has been aggrieved by a failure to take account of appellant's choice in assignment to a program.
5. For whom it is determined that protective or vendor payment will be established.
6. For whom it is determined that the individual must participate in a service program.
7. Who, as provided under rule 441—95.13(17A):
   - _ Is determined not to be entitled to a support rebate in full or in part because of the date of collection.
   - _ Is determined not to be entitled to a support payment in full or in part because of the date of collection.
   - _ Has not had a dispute based on the date of collection acted upon within 30 days.
8. Whose license, certification, approval, or accreditation has been denied or revoked.

A vendor, payee, parent of child(ren) in foster home or group care, adoptive applicant, an applicant for state community mental health and mental retardation services funds, and a person who has been denied expungement for correction of child abuse registry information may be an aggrieved person in certain situations.

A PROMISE JOBS participant who alleges acts of discrimination on the basis of race, sex, national origin, religion, age or handicapping condition may be an aggrieved person in certain situations.

A person who claims displacement by a PROMISE JOBS participant and who is dissatisfied with the results of informal grievance resolution procedures or who fails or refuses to receive informal grievance resolution procedures may be an aggrieved person in certain situations.

A person who has requested a specific rehabilitative treatment service as defined in rule 441—185.1(234) may be an aggrieved person if the referral worker does not make a referral to the review organization for the services requested or if the person is dissatisfied with the necessity, amount, duration, or scope of services as authorized by the review organization. Providers and referral workers who are dissatisfied with the amount, duration or scope of rehabilitative treatment services authorized shall not be considered an aggrieved person.

9. Who is contesting a claim, offset, or setoff as provided in 441—subrule 95.6(3), 95.7(8), or 98.81(3) by alleging a mistake of fact. Mistake of fact means a mistake in the identity of the obligor, or whether the delinquency meets the criteria for referral or submission. The issue on appeal shall be limited to a mistake of fact. Any other issue may only be determined by a court of competent jurisdiction.
10. Who is contesting a child care provider or child care assistance client claim, as provided in rule 441—170.9(234).
11. Who is contesting a risk assessment decision as provided in rule 441—103.34(692A) by alleging that the risk assessment factors have not been properly applied, the information relied upon to support the assessment findings is inaccurate, or the procedures were not correctly followed.

"Appeal" denotes a review and hearing request made by an appellant of a decision made by the agency or its designee. An appeal shall be considered a contested case within the meaning of Iowa Code chapter 17A.

"Appeals advisory committee" means a committee consisting of central office staff who represent the department in the screening of proposed decisions for the director.

"Appellant" denotes the person who claims or asserts a right or demand or the party who takes an appeal from a hearing to an Iowa district court.

"Contested case" means a proceeding defined by Iowa Code section 17A.2(5) and includes any matter defined as a no factual dispute contested case under 1998 Iowa Acts, chapter 1202, section 14.

"Department" means the Iowa department of human services.

"Department of inspections and appeals" means the state agency which contracts with the department to conduct appeal hearings.

"Due process" denotes the rights of a person affected by an agency decision to present a complaint at an appeal hearing and to be heard, by testimony or otherwise, and to have the right of controverting, by proof,

every material fact which bears on the questions of the person's rights in the matter involved without undue delay or hindrance.
"In person or face-to-face hearing" means an appeal hearing conducted by an administrative law judge who is physically present in the same location as the appellant.
"Issues of fact or judgment" denotes disputed issues of facts or of the application of state or federal law or policy to the facts of the individual's personal situation.
"Issues of policy" denotes issues of the legality, fairness, equity, or constitutionality of state or federal law or agency policy where the facts and applicability of the law or policy are undisputed.
"Joint or group hearings" denotes an opportunity for several persons to present their case jointly when all have the same complaint against agency policy.
"Local office" means the county, institution or district office of the department of human services.
"Presumption" denotes an inference drawn from a particular fact or facts or from particular evidence, which stands until the truth of the inference is disposed.
"PROMISE JOBS discrimination complaint" means any written complaint filed in accordance with the provisions of rule 441—7.8(17A) by a PROMISE JOBS participant or the participant's representative which alleges that an adverse action was taken against the participant on the basis of race, sex, national origin, religion, age or a handicapping condition.
"PROMISE JOBS displacement grievance" means any written complaint filed with a PROMISE JOBS contractee by regular employees or their representatives which alleges that the work assignment of an individual under the PROMISE JOBS program violates any of the prohibitions against displacement of regular workers described in subrule 93.21(3).
"Teleconference hearing" means an appeal hearing conducted by an administrative law judge over the telephone.
"Timely notice period" is the time from the date a notice is mailed to the effective date of action. That period of time shall be at least ten calendar days, except in the case of probable fraud of the appellant. When probable fraud of the appellant exists, "timely notice period" shall be at least five calendar days from the date a notice is sent by certified mail. When a license, approval, or certification issued by the department is to be revoked, timely notice period is 30 calendar days from the date a notice is mailed.
"Vendor" means a provider of health care under the medical assistance program or a provider of services under a service program.

441—7.2(17A) Application of rules. Appeals and hearings for the food stamp program are governed by rules 7.10(17A) and 7.21(17A). FIP disqualification hearings are governed by rule 7.22(17A). All other appeals and hearings are governed by rules 7.1(17A) to 7.20(17A).

441—7.3(17A) The administrative law judge. Appeal hearings shall be conducted by an administrative law judge appointed by the department of inspections and appeals pursuant to 1998 Iowa Acts, chapter 1202, section 3. The administrative law judge shall not be connected in any way with the previous actions or decisions on which the appeal is made. Nor shall the administrative law judge be subject to the authority, direction, or discretion of any person who has prosecuted or advocated in connection with that case, the specific controversy underlying that case, or pending factually related contested case or controversy, involving the same parties.

441—7.4(17A) Publication and distribution of hearing procedures. Hearing procedures shall be published and widely distributed in the form of rules or a clearly stated pamphlet, and shall be made available to all applicants, recipients, appellants, and other interested groups and individuals.

441—7.5(17A) The right to appeal. Any person or group of persons may file an appeal with the department concerning any issue. The department shall determine whether a hearing shall be granted.
7.5(1) *When a hearing is granted.* A hearing shall be granted to any appellant when the right to a hearing is granted by state or federal law or Constitution, except as limited in subrules 7.5(2) and 7.5(4).
7.5(2) *When a hearing is not granted.* A hearing shall not be granted when:
a. One of the following issues is appealed:
(1) Services are changed from one plan year to the next in the social service block grant preexpenditure report and as a result the service is no longer available.

(2) Service has been time-limited in the social service block grant preexpenditure report and as a result the service is no longer available.
(3) Payment for a medical claim has been made in accordance with the Medicaid payment schedule for the service billed.
(4) Children have been removed from or placed in a specific foster care setting.
b. Either state or federal law requires automatic grant adjustment for classes of recipients. The director of the department shall decide whether to grant a hearing in these cases. When the reason for an individual appeal is incorrect grant computation in the application of these automatic adjustments, a hearing may be granted.
c. State or federal law or regulation provides for a different forum for appeals.
d. The appeal is filed prematurely as there is no adverse action by the department.
e. Upon review, it is determined that the appellant does not meet the criteria of an aggrieved person as defined in rule 441—7.1(17A).
f. The sole basis for denying, terminating or limiting assistance under 441—Chapter 47, Division I, II or III, or 441—Chapter 58 is that funds for the respective programs have been reduced, exhausted, eliminated or otherwise encumbered.
7.5(3) *Group hearings*. The department may respond to a series of individual requests for hearings by requesting the department of inspections and appeals to conduct a single group hearing in cases in which the sole issue involved is one of state or federal law or policy or changes in state or federal law. An appellant scheduled for a group hearing may withdraw and request an individual hearing.
7.5(4) *Time limit for granting hearing to an appeal.* Subject to the provisions of subrule 7.5(1), when an appeal is made, the granting of a hearing to that appeal shall be governed by the following timeliness standards:
a. If the appeal is made within 30 days after official notification of an action, or before the effective date of action, a hearing shall be held.
b. When the appeal is made more than 30 days, but less than 90 days after notification, the director shall determine whether a hearing shall be granted. The director may grant a hearing if one or more of the following conditions existed:
(1) There was a serious illness or death of the appellant or a member of the appellant's family.
(2) There was a family emergency or household disaster, such as a fire, flood, or tornado.
(3) The appellant offers a good cause beyond the appellant's control, which can be substantiated.
(4) There was a failure to receive the department's notification for a reason not attributable to the appellant. Lack of a forwarding address is attributable to the appellant.
c. The time in which to appeal an agency action shall not exceed 90 days. Appeals made more than 90 days after notification shall not be heard.
d. The day after the official notice is mailed is the first day of the time period within which an appeal must be filed. When the time limit for filing falls on a holiday or a weekend, the time will be extended to the next workday.
e. PROMISE JOBS displacement and discrimination appeals shall be granted hearing on the following basis:
(1) An appeal of an informal grievance resolution on a PROMISE JOBS displacement grievance shall be made in writing within ten days of issuance (i.e., mailing) of the resolution decision or within 24 days of the filing of the displacement grievance, whichever is the shorter time period, unless good cause for late filing as described in paragraph *"b"* is found.
(2) An appeal of a PROMISE JOBS discrimination complaint shall be made within the time frames provided in paragraphs *"a," "b,"* and *"c"* in relation to the action alleged to have involved discrimination unless good cause for late filing as described in paragraph *"b"* is found.
f. An appeal of a sex offender risk assessment shall be made in writing within 14 calendar days of issuance of the notice.
7.5(5) *Informal settlements*. The time limit for submitting an appeal is not extended while attempts at informal settlement are in progress. Prehearing conferences are provided for at subrules 7.7(4) and 7.8(4).
7.5(6) *Appeals of family investment program (FIP) and refugee cash assistance (RCA) overpayments*. Subject to the time limitations described in subrule 7.5(4), a person's right to appeal the existence, computation, and amount of a FIP or RCA overpayment begins when the person receives the first Form 470-2616, Demand Letter for FIP/RCA Agency Error Overissuance, Form 470-3489, Demand Letter for FIP/RCA Intentional Program Violation Overissuance, or Form 470-3490, Demand Letter for FIP/RCA

Client Error Overissuance, from the department of human services, informing the person of the FIP or RCA overpayment. A hearing shall not be held if an appeal is filed in response to a second or subsequent Demand Letter for FIP/RCA Agency Error Overissuance, Demand Letter for FIP/RCA Intentional Program Violation Overissuance, or Demand Letter for FIP/RCA Client Error Overissuance. Subject to the time limitations described in subrule 7.5(4), a person's right to appeal the recovery of an overpayment through benefit reduction, as described at rule 441—46.25(239B), but not the existence, computation, or amount of an overpayment, begins when the person receives Form 470-0486, Notice of Decision, informing the person that benefits will be reduced to recover a FIP or RCA overpayment.

7.5(7) *Appeals of Medicaid and state supplementary assistance (SSA) overpayments. A* person's right to appeal the existence and amount of a Medicaid or SSA overpayment begins when the person receives the first Form 470-2891, Notice of Overpayment, Demand Letter for the Medicaid or State Supplementary Assistance Overpayment, from the department of human services, informing the person of the Medicaid or SSA overpayment, and is subject to the time limitations described in subrule 7.5(4).

7.5(8) *Appeal rights under the family investment program limited benefit plan.* A participant only has the right to appeal the establishment of the limited benefit plan once at the time the department issues the timely and adequate notice that establishes the limited benefit plan. However, when the reason for the appeal is based on an incorrect grant computation, an error in determining the eligible group, or another worker error, a hearing shall be granted when the appeal otherwise meets the criteria for hearing.

7.5(9) *Appeals of child care assistance benefit overissuances or overpayments.* Subject to the time limitations described in subrule 7.5(4), a person's right to appeal the existence, computation, and amount of a child care assistance benefit overissuance or overpayment begins when the person receives the first Form 470-3627, Demand Letter for Child Care Assistance Provider Error Overissuance, or Form 470-3628, Demand Letter for Child Care Assistance Client Error Benefit Overissuance, from the department of human services, informing the person of the child care assistance overpayment. A hearing shall not be held if an appeal is filed in response to a second or subsequent Demand Letter for Child Care Assistance Provider Error Overissuance or Demand Letter for Child Care Assistance Client Error Benefit Overissuance.

441—7.6(17A) Informing persons of their rights.

7.6(1) *Written and oral notification*. The department shall advise each applicant and recipient of the right to appeal any adverse decision affecting the person's status. Written notification of the following shall be given at the time of application and at the time of any agency action affecting the claim for assistance.

a. The right to request a hearing.

b. The procedure for requesting a hearing.

c. The right to be represented by others at the hearing unless otherwise specified by statute or federal regulation.

d. Provisions, if any, for payment of legal fees by the department.

Written notification shall be given on the application form and pamphlets prepared by the agency for applicants and recipients. Explanation shall be included in the agency pamphlets explaining the various provisions of the program. Oral explanation shall also be given regarding the policy on appeals during the application process and at the time of any contemplated action by the agency when the need for an explanation is indicated. Persons not familiar with English shall be provided a translation into the language understood by them in the form of a written pamphlet or orally. In all cases when a person is illiterate or semiliterate, the person shall, in addition to receiving the written pamphlet on rights, be advised of each right to the satisfaction of the person's understanding.

7.6(2) *Representation.* All persons shall be advised that they may be represented at hearings by others, including legal counsel, relatives, friends, or any other spokesperson of choice, unless otherwise specified by statute or federal regulations. The agency shall advise the persons of any legal services which may be available and assist in securing the services if the persons desire.

441—7.7(17A) Notice of intent to approve, deny, terminate, reduce, or suspend assistance or deny reinstatement of assistance.

7.7(1) *Notification*. Whenever the department proposes to terminate, reduce, or suspend food stamps, financial assistance, Medicaid, or services, it shall give timely and adequate notice of the pending action, except when a service is deleted from the state's comprehensive annual service plan in the social services block grant program at the onset of a new program year or as provided in subrule 7.7(2).

Whenever the department proposes to approve or deny food stamps, financial assistance, Medicaid, or services, it shall give adequate notice of the action.

a. Timely means that the notice is mailed at least ten calendar days before the date the action would become effective. The timely notice period shall begin on the day after the notice is mailed.

b. Adequate means a written notice that includes:

(1) A statement of what action is being taken,

(2) The reasons for the intended action,

(3) The manual chapter number and subheading supporting the action,

(4) An explanation of the appellant's right to appeal, and

(5) The circumstances under which assistance is continued when an appeal is filed.

7.7(2) *Dispensing with timely notice*. Timely notice may be dispensed with, but adequate notice shall be sent no later than the date benefits would have been issued when:

a. There is factual information confirming the death of a recipient or of the family investment program payee when there is no relative available to serve as a new payee.

b. The recipient provides a clear written, signed statement that the recipient no longer wishes assistance, or gives information which requires termination or reduction of assistance, and the recipient has indicated, in writing, that the recipient understands this must be the consequence of supplying the information.

c. The recipient has been admitted or committed to an institution which does not qualify for payment under an assistance program.

d. The recipient has been placed in skilled nursing care, intermediate care, or long-term hospitalization.

e. The recipient's whereabouts are unknown and mail directed to the recipient has been returned by the post office indicating no known forwarding address. When the recipient's whereabouts become known during the payment period covered by the returned warrant, the warrant shall be made available to the recipient.

f. The county establishes that the recipient has been accepted for assistance in a new jurisdiction.

g. Cash assistance or food stamps are changed because a child is removed from the home as a result of a judicial determination or voluntarily placed in foster care.

h. A change in the level of medical care is prescribed by the recipient's physician.

i. A special allowance or service granted for a specific period is terminated and the recipient has been informed in writing at the time of initiation that the allowance or service shall terminate at the end of the specified period.

j. Rescinded, effective 2/1/84.

k. The agency terminates, reduces, or suspends benefits or makes changes based on the completed Form 470-0455 or Form 470-3719(S), Public Assistance Eligibility Report, or Form 470-2881, Review/Recertification Eligibility Document, as described at 441—paragraph 40.27(1)*"b."*

l. The agency terminates benefits for failure to return a completed monthly report form, as described in paragraph *"k."*

m. The agency approves or denies an application for assistance.

7.7(3) *Action due to probable fraud.* When the agency obtains facts indicating that assistance should be discontinued, suspended, terminated, or reduced because of the probable fraud of the recipient, and, where possible, the facts have been verified through collateral sources, notice of the grant adjustment shall be timely when mailed at least five calendar days before the action would become effective. The notice shall be sent by certified mail, return receipt requested.

7.7(4) *Conference during the timely notice period*. During the timely notice period, the appellant may have a conference to discuss the situation and the agency shall provide a full explanation of the reasons for the pending action and give the recipient an opportunity to offer facts to support the contention that the pending action is not warranted. The appellant may be accompanied by a representative, legal counsel, friend or other person and this person may represent the appellant when the appellant is not able to be present unless otherwise specified by statute or federal regulation.

7.7(5) *Notification not required.* Notification is not required in the following instances:

a. When services in the social service block grant preexpenditure report are changed from one plan year to the next, or when the plan is amended because funds are no longer available.

b. When service has been time-limited in the social service block grant preexpenditure report, and as a result the service is no longer available.

c. When the placement of a person(s) in foster care is changed.

d. When payment has been in accordance with the Medicaid payment schedule for the service billed because there is no adverse action.

7.7(6) *Reinstatement*. Whenever the county office determines that a previously canceled case must remain canceled for a reason other than that covered by the original notice, timely and adequate notice shall be sent except as specified in subrule 7.7(2). Whenever the county office determines that a previously canceled case is eligible for reinstatement at a lower level of benefits, for a reason other than that covered by the original notice, timely and adequate notice shall be sent except as specified in subrule 7.7(2). Food stamp cases are eligible for reinstatement only in circumstances found in rules 441—65.44(234) and 65.143(234) and 441—subrules 65.19(13) and 65.119(13). FIP cases are eligible for reinstatement only in circumstances found in 441—subrules 40.2(5) and 40.22(5).

441—7.8(17A) Opportunity for hearing.

7.8(1) *Initiating a request*. When a person, or the person's authorized representative, expresses in writing to the local office or the office that took the adverse action, dissatisfaction with any decision, action, or failure to act with reference to the case, the agency shall determine from the nature of the complaint whether the person wishes to appeal and receive an appeal hearing before an administrative law judge.

7.8(2) *Filing the appeal.* The appellant shall be encouraged, but not required, to make written appeal on Form PA-3138-0, part I, Appeal and Hearing Request, and the worker shall provide any instructions or assistance required in completing the form. When the appellant is unwilling to complete or sign this form, nothing in this rule shall be construed to preclude the right to perfect the appeal, as long as the appeal is in writing and has been communicated to the department by the appellant or appellant's representative. A written appeal is filed on the date postmarked on the envelope sent to the department, or, when the postmarked envelope is not available, on the date the appeal is stamped received by the agency. Receipt date of all appeals shall be documented by the office where the appeal is received.

7.8(3) Rescinded IAB 12/13/89, effective 2/1/90.

7.8(4) *Prehearing conference*. When desired by the appellant, a prehearing conference with a representative of the local office or the office which took the action appealed shall be held as soon as possible after the appeal has been filed. An appellant's representative shall be allowed to attend and participate in the conference, unless precluded by federal rule or state statute. The purpose of the prehearing conference is to provide information as to the reasons for the intended adverse action, to answer questions, to explain the basis for the adverse action, to provide an opportunity for the appellant to explain the appellant's action or position, and to provide an opportunity for the appellant to examine the contents of the case record plus all documents and records to be used by the department at the hearing in accordance with 441—Chapter 9. A conference need not be requested for the appellant to have access to the records as provided in subrule 7.13(1) and 441—Chapter 9.

7.8(5) *Interference*. The conference shall not be used to discourage appellants from proceeding with their appeals. The right of appeal shall not be limited or interfered with in any way, even though the person's complaint may be without basis in fact, or because of the person's own misinterpretation of law, agency policy, or methods of implementing policy.

7.8(6) *Right of the department to deny or dismiss an appeal.* The department or the department of inspections and appeals has the right to deny or dismiss the appeal when:

a. It has been withdrawn by the appellant in writing.

b. The sole issue is one of state or federal law requiring automatic grant adjustments for classes of recipients.

c. It has been abandoned.

d. The agency, by written notice, withdraws the action appealed and restores the appellant's status which existed before the action appealed was taken.

e. The agency implements action and issues a notice of decision to correct an error made by the agency which resulted in the appeal.

Abandonment may be deemed to have occurred when the appellant, or the appellant's authorized representative fails, without good cause, to appear at the hearing.

7.8(7) *Denial of due process.* Facts of harassing, threats of prosecution, denial of pertinent information needed by the appellant in preparing the appeal, as a result of the appellant's communicated desire to proceed with the appeal shall be taken into consideration by the administrative law judge in reaching a proposed decision.

7.8(8) *Withdrawal*. When the appellant desires to voluntarily withdraw the appeal, the worker shall request the appellant to sign Form PA-3161-0, Request for Withdrawal of Appeal, if the appellant is in the local office. In all other cases the bureau of policy analysis will request the appellant sign the form or the administrative law judge will secure a statement on the hearing record.
7.8(9) *Department's responsibilities*. Unless the appeal is voluntarily withdrawn, the department worker or agent responsible for representing the department at the hearing shall:
a. Immediately complete part II of Form PA-3138-0, Appeal and Hearing Request, and shall forward that form, the written appeal, and a copy of the notification of the proposed adverse action to the bureau of policy analysis, appeals section. Immediately shall mean within one working day of receipt.
b. Forward a summary and supporting documentation of the worker's factual basis for the proposed action to the bureau of policy analysis, appeals section, within ten days of the receipt of the appeal.
c. Provide copies of all materials sent to the bureau of policy analysis, appeals section, for inclusion in the appeal file to be considered in reaching a decision on the appeal, to the appellant and appellant's representative at the same time.

441—7.9(17A) Continuation of assistance pending a final decision on appeal.
7.9(1) *When assistance continues.* Assistance shall not be suspended, reduced, restricted, discontinued or terminated, nor shall a license or registration be revoked, or other proposed adverse action be taken pending a final decision on an appeal when:
a. An appeal is filed within the timely notice period.
b. The appellant requests a hearing within ten days from the date adequate notice is issued for termination, reduction, or suspension of benefits, food stamps, family investment program or Medicaid, based on the completed monthly report. If it is determined at a hearing that the issue involves only federal or state law or policy, assistance will be immediately discontinued.
7.9(2) *When assistance does not continue.* The adverse action appealed to suspend, reduce, restrict, discontinue, or terminate assistance, revoke a license or registration, or take other proposed action may be implemented pending a final decision on appeal when:
a. An appeal is not filed within the timely notice period.
b. The appellant does not request a hearing within ten days from the date adequate notice is issued based on the completed monthly report.
c. A food stamp certification ends.
d. A medically needy certification period ends.
e. A transitional child care assistance certification period ends.
f. The appellant directs the worker in writing to proceed with the intended action.
7.9(3) *Recovery of excess assistance paid pending a final decision on appeal*. Continued assistance is subject to recovery by the department if its action is affirmed, except as specified at subrule 7.9(5). When the department action is sustained, excess assistance paid pending a hearing decision shall be recovered to the date of the decision. This recovery is not an appealable issue. However, appeals may be heard on the computation of excess assistance paid pending a hearing decision.
7.9(4) *Recovery of excess assistance paid when the appellant's benefits are changed prior to a final decision.* Recovery of excess assistance paid will be made to the date of change which affects the improper payment. The recovery shall be made when the appellant's benefits are changed due to one of the following reasons:
a. A determination is made at the hearing that the sole issue is one of state or federal law or policy or change in state or federal law and not one of incorrect grant computation, and the grant is adjusted.
b. A change affecting the appellant's grant occurs while the hearing decision is pending and the appellant fails to request a hearing after notice of the change.
7.9(5) *Recovery of assistance when a new limited benefit plan is established.* Assistance issued pending the final decision of the appeal is not subject to recovery when a new limited benefit plan period is established. A new limited benefit plan period shall be established when the department is affirmed in a timely appeal of the establishment of the limited benefit plan. All of the following conditions shall exist:
a. The appeal is filed within the timely notice period of the notice of decision establishing the beginning date of the LBP.
b. Assistance is continued pending the final decision of the appeal.
c. The department's action is affirmed.

441—7.10(17A) Procedural considerations. Upon receipt of the notice of appeal, the department shall:
7.10(1) *Registration*. Register the appeal.
7.10(2) *Acknowledgment*. Send an acknowledgment of receipt of the appeal to the appellant, representative, or both.
A copy of the acknowledgment of receipt of appeal will be sent to the appropriate departmental office.
7.10(3) *Granting a hearing*. The department shall determine whether an appellant may be granted a hearing and the issues to be discussed at that hearing in accordance with the applicable rules, state statutes, or federal regulations.
a. The appeals of those appellants who are granted a hearing shall be certified to the department of inspections and appeals for the hearing to be conducted. The department shall indicate at the time of certification the issues to be discussed at that hearing.
b. The appeals of those appellants who are denied a hearing shall not be closed until issuance of a letter to the appellant and the appellant's representative, advising of the denial of hearing and the basis upon which that denial is made. Any appellant that disagrees with a denial of hearing may present additional information relative to the reason for denial and request reconsideration by the department or a hearing over the denial.
7.10(4) *Hearing scheduled*. For those records certified for hearing, the department of inspections and appeals shall establish the date, time, method and place of the hearing, with due regard for the convenience of the appellant as set forth in department of inspections and appeals rules 481—Chapter 10 unless otherwise designated by federal or state statute or regulation.
a. In cases involving individual appellants, the hearing shall be held in the appropriate departmental office, provided that when the appellant is incapacitated due to illness or other disability and is housebound, hospitalized, or in a nursing home, the place of the hearing shall be at the convenience of the appellant even to the extent of holding the hearing in the appellant's home except where otherwise restricted.
b. In cases of appeals by vendors or agencies, the hearing shall be scheduled at the most appropriate department office, giving due consideration to the convenience of the vendor or agency and availability of department employees.
c. In cases involving the determination of the community spouse resource allowance, the hearing shall be held within 30 days of the date of the appeal request.
d. In cases involving an appeal of a sex offender risk assessment, the hearing shall be held within 30 days of the date of the appeal request.
7.10(5) *Method of hearing*. The department of inspections and appeals shall determine whether the appeal hearing is to be conducted in person or by teleconference call. Any appellant is entitled to an in-person hearing if desired. All parties shall be granted the same rights during a teleconference hearing as specified in 441—7.13(17A).
7.10(6) *Reschedule requests*. Requests by the appellant or the department to set another date, time, method or place of hearing shall be made to the department of inspections and appeals directly except as otherwise noted. The granting of the requests will be at the discretion of the department of inspections and appeals.
a. The appellant may request that the teleconference hearing be rescheduled as an in-person hearing. All requests made to the department or to the department of inspections and appeals for a teleconference hearing to be rescheduled as an in-person hearing shall be granted. Any appellant request for an in-person hearing made to the department shall be communicated to the department of inspections and appeals immediately.
b. All other requests concerning the scheduling of a hearing shall be made to the department of inspections and appeals directly.
7.10(7) *Notification*. For those appeals certified for hearing, the department of inspections and appeals shall send a notice to the appellant at least ten calendar days in advance of the hearing date. The notice, as prescribed in Iowa Code section 17A.12(2), shall set forth the date, time, method and place of the hearing, that evidence may be presented orally or documented to establish pertinent facts, and that the appellant may question or refute any testimony, may bring witnesses of the appellant's choice and may be represented by others, including an attorney, subject to federal law and state statute.
a. A copy of this notice shall be forwarded to the local administrator, the district office, and other persons when circumstances peculiar to the case indicate that the notification may be desirable.
b. The notice may be served upon the appellant by personal service as in civil actions, or by certified mail, return receipt requested, or by first-class mail, postage prepaid, addressed to the appellant at the last known address.

441—7.11(17A) Information and referral for legal services. The local office shall advise persons appealing any agency decision of legal services in the community that are willing to assist them.

441—7.12(17A) Subpoenas. The department shall have all subpoena power conferred upon it by statute. Departmental subpoenas shall be issued to a party on request or will be served by the department when requested at least one week in advance of the hearing date.

441—7.13(17A) Rights of appellants during hearings.
7.13(1) *Examination of the evidence*. The department shall provide the appellant, or representative, opportunity prior to, as well as during, the hearing, to examine all materials permitted under rule 9.1(17A,22) or to be offered as evidence. Off the record, or confidential information which the appellant or representative does not have the opportunity to examine shall not be included in the record of the proceedings or considered in reaching a decision.
7.13(2) *Conduct of hearing.* The hearing shall be conducted by an administrative law judge designated by the department of inspections and appeals. It shall be an informal rather than a formal judicial procedure, and shall be designed to serve the best interest of the appellant. The appellant shall have the right to introduce any evidence on points at issue believed necessary, and to challenge and crossexamine any statement made by others, and to present evidence in rebuttal. A verbatim record shall be kept of the evidence presented.
7.13(3) *Opportunity for response.* Opportunity shall be afforded all parties to respond and present evidence and arguments on all issues involved and to be represented by counsel at their own expense.
7.13(4) *Default.* If a party to the appeal fails to appear or participate in a contested case proceeding after proper service of notice, the presiding officer may, if no adjournment is granted, enter a default decision or proceed with the hearing and render a proposed decision on the merits in the absence of the defaulting party.
a. Where appropriate and not contrary to law, any party may move for a default decision or for a hearing and a proposed decision on the merits in the absence of a defaulting party.
b. A default decision or a proposed decision on the merits in the absence of the defaulting party may award any relief against the defaulting party consistent with the relief requested prior to the default, but the relief awarded against the defaulting party may not exceed the requested relief prior to the default.
c. Proceedings after a default decision are specified in subrule 7.13(5).
d. Proceedings after a hearing and a proposed decision on the merits in the absence of a defaulting party are specified in subrule 7.13(6).
7.13(5) *Proceedings after default decision.*
a. Default decisions become final agency action unless a motion to vacate the decision is filed within the time allowed for an appeal of a proposed decision by subrule 7.16(5).
b. A motion to vacate must state all facts relied upon by the moving party which establish that good cause existed for the party's failure to appear or participate at the contested case proceeding and must be filed with the Department of Human Services Appeals Section, Fifth Floor, Hoover State Office Building, Des Moines, Iowa 50319-0114. The department of human services appeals section shall be responsible for serving all parties with the motion to vacate. All parties to the appeal shall have ten days from service by the department to respond to the motion to vacate. If the department responds to any party's motion to vacate, all parties shall be allowed another ten days to respond to the department. The department of human services appeals section shall certify the motion to vacate to the department of inspections and appeals for the presiding officer to review the motion, hold any additional proceedings, as appropriate, and determine if good cause exists for the default.
c. Timely filed motions to vacate shall be granted only for good cause shown. The burden of proof as to good cause is on the moving party.
d. "Good cause" for purposes of this rule shall have the same meaning as "good cause" for setting aside a default judgment under Iowa Rule of Civil Procedure 236.
e. Upon determining whether good cause exists, the presiding officer shall issue a proposed decision on the motion to vacate, which shall be subject to review by the director pursuant to rule 441—7.16(17A).
f. Upon a final decision granting a motion to vacate, the contested case hearing shall proceed accordingly, after proper service of notice to all parties. The situation shall be treated as the filing of a new appeal for

purposes of calculating time limits, with the filing date being the date the decision granting the motion to vacate became final.
g. Upon a final decision denying a motion to vacate, the default decision becomes final agency action.
7.13(6) *Proceedings after hearing and proposed decision on the merits in the absence of a defaulting party.*
a. Proposed decisions on the merits after a party has failed to appear or participate in a contested case become final agency action unless:
(1) A motion to vacate the proposed decision is filed by the defaulting party based on good cause for the failure to appear or participate, within the time allowed for an appeal of a proposed decision by subrule 7.16(5); or
(2) Any party requests review on the merits by the director pursuant to rule 441—7.16(17A).
b. If a motion to vacate and a request for review on the merits are both made in a timely manner after a proposed decision on the merits in the absence of a defaulting party, the review by the director on the merits of the appeal shall be stayed pending the outcome of the motion to vacate.
c. A motion to vacate must state all facts relied upon by the moving party which establish that good cause existed for the party's failure to appear or participate at the contested case proceeding and must be filed with the Department of Human Services Appeals Section, Fifth Floor, Hoover State Office Building, Des Moines, Iowa 50319-0114. The department of human services appeals section shall be responsible for serving all parties with the motion to vacate. All parties to the appeal shall have ten days from service by the department to respond to the motion to vacate. If the department responds to any party's motion to vacate, all parties shall be allowed another ten days to respond to the department. The department of human services appeals section shall certify the motion to vacate to the department of inspections and appeals for the presiding officer to review the motion, hold any additional proceedings, as appropriate, and determine if good cause exists for the default.
d. Timely filed motions to vacate shall be granted only for good cause shown. The burden of proof as to good cause is on the moving party.
e. "Good cause" for purposes of this rule shall have the same meaning as "good cause" for setting aside a default judgment under Iowa Rule of Civil Procedure 236.
f. Upon determining whether good cause exists, the presiding officer shall issue a proposed decision on the motion to vacate, which shall be subject to review by the director pursuant to rule 441—7.16(17A).
g. Upon a final decision granting a motion to vacate, a new contested case hearing shall be held after proper service of notice to all parties. The situation shall be treated as the filing of a new appeal for purposes of calculating time limits, with the filing date being the date the decision granting the motion to vacate became final.
h. Upon a final decision denying a motion to vacate, the proposed decision on the merits in the absence of a defaulting party becomes final unless there is request for review on the merits by the director made pursuant to paragraph 7.13(6)*"a"* or *"j."*
i. Any review on the merits by the director requested pursuant to paragraph 7.13(6)*"a"* and stayed pursuant to paragraph 7.13(6)*"b"* pending a decision on a motion to vacate shall be conducted upon a final decision denying the motion to vacate.
j. Upon a final decision denying a motion to vacate a proposed decision issued in the absence of a defaulting party, any party to the contested case proceeding may request a review on the merits by the director pursuant to rule 441—7.16(17A), treating the date that the denial of the motion to vacate became final as the date of the proposed decision.

441—7.14(17A) Limitation of persons attending. The hearing shall be limited in attendance to the following persons, unless otherwise specified by statute or federal regulations: appellant, appellant's representative, agency employees, agency's legal representatives, other persons present for the purpose of offering testimony pertinent to the issues in controversy, and others upon mutual agreement of the parties. The administrative law judge may sequester witnesses during the hearing. Nothing in this rule shall be construed to allow members of the press, news media, or any other citizens' group to attend the hearing without the written consent of the appellant.

441—7.15(17A) Medical examination. When the hearing involves medical issues, a medical assessment or examination by a person or physician other than the one involved in the decision under question shall be obtained and the report made a part of the hearing record when the administrative law judge or appellant considers it necessary. Any medical examination required shall be performed by a physician satisfactory to

the appellant and the department at agency expense. Forms PA-5113-0, Authorization for Examination and Claim for Payment, and PA-2126-5, Report on Incapacity, shall be utilized in obtaining medical information to be used in the appeal and to authorize payment for the examination.

441—7.16(17A) The appeal decision.

7.16(1) *Record*. The record in a contested case shall include, in addition to those materials specified in Iowa Code section 17A.12(6):

a. The notice of appeal.

b. All evidence received or considered and all other submissions, including the verbatim record of the hearing.

7.16(2) *Findings of fact.* Findings of fact shall be based solely on the evidence in the record and on matters officially noticed in the record. The findings of fact and conclusions of law in the proposed or final decision shall be limited to contested issues of fact or policy.

7.16(3) *Proposed decision*. Following the reception of evidence, the administrative law judge shall issue a proposed decision, consisting of findings of fact and conclusions of law, separately stated.

7.16(4) *Appeal of the proposed decision.* After issuing a proposed decision the administrative law judge shall submit it to the department with copies to the appeals advisory committee. The appellant, appellant's representative, or the department may appeal for the director's review of the proposed decision. When the appellant or the department has not appealed the proposed decision or an appeal for the director's review of the proposed decision is not granted, the proposed decision shall become the final decision. The director's review on appeal of the proposed decision shall be on the basis of the record as defined in subrule 7.16(1), except that the director need not listen to the verbatim record of the hearing in a review or appeal. The review or appeal shall be limited to issues raised prior to that time and specified by the party requesting the appeal or review. The director may designate another to act on the director's behalf in making final decisions.

7.16(5) *Time limit for appeal of a proposed decision.* Appeal for the director's review of the proposed decision must be made in writing to the director within ten calendar days of the date on which the proposed decision was signed and mailed. The day after the proposed decision is mailed is the first day of the time period within which a request for review must be filed. When the time limit for filing falls on a holiday or a weekend, the time will be extended to the next workday.

7.16(6) *Appeal of the proposed decision by the department.* The appeals advisory committee acts as an initial screening device for the director and may recommend that the director review a proposed decision. That recommendation is not binding upon the director, and the director may decide to review a proposed decision without that committee's recommendation. When a review of a proposed decision on the department's appeal is granted by the director, the appellant and appellant's representative shall be notified of the review and the department's basis for requesting the review. The appellant or appellant's representative shall be provided ten calendar days from the date of notification to file exceptions, present briefs, and submit further written arguments or objections for consideration upon review. The day after the notification is mailed is the first day of the time period within which a response to the department's request for review must be filed. When the time limit for responding falls on a holiday or a weekend, the time will be extended to the next workday.

7.16(7) *Appeal of the proposed decision by the appellant.* When a review of a proposed decision on the appellant's or appellant's representative's appeal is granted by the director, the appellant and appellant's representative shall be so notified.

7.16(8) *Opportunity for oral presentation of appeal of the proposed decision*. In cases where there is an appeal of a proposed decision each party shall be afforded an opportunity to present oral arguments with the consent of the director. Any party wishing oral argument shall specifically request it. When granted, all parties shall be notified of the time and place.

7.16(9) *Time limit.* Prompt, definite and final administrative action to carry out the decision rendered shall be taken within 90 days from the date of the appeal on all decisions except food stamps and vendors. Food stamp-only decisions shall be rendered in 60 days. Vendor decisions shall be rendered in 120 days. PROMISE JOBS displacement grievance decisions shall be rendered within 90 days from the date the displacement grievance was filed with the PROMISE JOBS contractee.

a. Should the appellant request a delay in the hearing in order to prepare the case or for other essential reasons, reasonable time, not to exceed 30 days except with the approval of the administrative law judge, shall be granted and the extra time shall be added to the maximum for final administrative action.

b. Immediately upon receipt of a copy of the final decision, the local office shall take the action required by the decision. A report of that action shall be submitted to the bureau of policy analysis, appeals section, within seven calendar days of the date of the final decision. When the final decision is favorable to the appellant, or when the agency decides in favor of the appellant prior to the hearing, correct payments retroactive to the date of the incorrect action shall be made.

441—7.17(17A) Exhausting administrative remedies. To have exhausted all adequate administrative remedies, a party need not request a rehearing under Iowa Code section 17A.16(2) where the party accepts the findings of fact as prepared by the administrative law judge, but wishes to challenge the conclusions of law, or departmental policy.

441—7.18(17A) Ex parte communication.
7.18(1) *Prohibited communication.* Unless required for the disposition of ex parte matters specifically authorized by statute, following issuance of the notice of hearing, there shall be no communication, directly or indirectly, between the presiding officer and any party or representative of any party or any other person with a direct or indirect interest in such case in connection with any issue of fact or law in the case except upon notice and opportunity for all parties to participate. This does not prohibit persons jointly assigned such tasks from communicating with each other. Nothing in this provision is intended to preclude the presiding officer from communicating with members of the agency or seeking the advice or help of persons other than those with a personal interest in, or those engaged in personally investigating, prosecuting, or advocating in, either the case under consideration or a pending factually related case involving the same parties as long as those persons do not directly or indirectly communicate to the presiding officer any ex parte communications they have received of a type that the presiding officer would be prohibited from receiving or that furnish, augment, diminish, or modify the evidence in the record. For purposes of this rule, the term "personally investigating" means taking affirmative steps to interview witnesses directly or to obtain documents or other information directly. The term does not include general direction and supervision of assigned investigators, unsolicited receipt of information which is relayed to assigned investigators, review of another person's investigative work product in the course of determining whether there is probable cause to initiate a proceeding, or exposure to factual information while performing other agency functions, including fact gathering for purposes other than investigation of the matter which culminates in a contested case.
7.18(2) *Commencement of prohibition*. Prohibitions on ex parte communications commence with the issuance of the notice of hearing in a contested case and continue for as long as the case is pending.
7.18(3) *When communication is ex parte.* Written, oral, or other forms of communication are "ex parte" if made without notice and opportunity for all parties to participate.
7.18(4) *Avoidance of ex parte communication.* To avoid prohibited ex parte communications, notice must be given in a manner reasonably calculated to give all parties a fair opportunity to participate. Written communications shall be provided to all parties to the appeal.
7.18(5) *Communications not prohibited.* Communications with the presiding officer involving uncontested scheduling or procedural matters do not require notice or opportunity for parties to participate. Parties should notify other parties prior to initiating such contact with the presiding officer when feasible, and shall notify other parties when seeking to continue hearings or other deadlines.
7.18(6) *Disclosure of prohibited communications.* A presiding officer who receives a prohibited ex parte communication during the pendency of a contested case must initially determine if the effect of the communication is so prejudicial that the presiding officer should be disqualified from the case. If the presiding officer determines that disqualification is warranted, a copy of any prohibited written communication, all written responses to the communication, a written summary stating the substance of any prohibited oral or other communication not available in written form for disclosure, all responses made, and the identity of each person from whom the presiding officer received a prohibited ex parte communication shall be disclosed. If the presiding officer determines that disqualification is not warranted, such documents shall be submitted for inclusion in the record and served on all parties. Any party desiring to rebut the prohibited communication must be allowed the opportunity to do so upon written request filed within ten days after notice of communication.
7.18(7) *Disclosure of prior receipt of information through ex parte communication.* Promptly after being assigned to serve as presiding officer at any stage in a contested case proceeding, a presiding officer shall disclose to all parties material factual information received through ex parte communication prior to such

assignment unless the factual information has already been or shortly will be disclosed pursuant to Iowa Code section 17A.13(2) or through discovery. Factual information contained in an investigative report or similar document need not be separately disclosed by the presiding officer as long as such documents have been or will shortly be provided to the parties.
7.18(8) *Imposition of sanctions.* The presiding officer may render a proposed or final decision imposing appropriate sanctions for violations of this rule, including default, a decision against the offending party, censure, or suspension or revocation of the privilege to practice before the agency. Violation of ex parte communication prohibitions by department personnel shall be reported to the department for possible sanctions, including censure, suspension, dismissal, or other disciplinary action.

441—7.19(17A) Accessibility of hearing decisions. Summary reports of all hearing decisions shall be made available to local offices and the public. The information shall be presented in a manner consistent with requirements for safeguarding personal information concerning applicants and recipients.

441—7.20(17A) Right of judicial review and stays of agency action.
7.20(1) *Right of judicial review.* If a director's review is requested, the final decision shall advise the appellant of the right to judicial review by the district court. When the appellant is dissatisfied with the final decision, and appeals the decision to the district court, the department shall furnish copies of the documents or supporting papers which the appellant and legal representative may need in order to perfect the appeal to district court, including a written transcript of the hearing. An appeal of the final decision to district court does not itself stay execution or enforcement of an agency action.
7.20(2) *Stays of agency action.*
a. Any party to a contested case proceeding may petition the director for a stay or other temporary remedies pending judicial review, of all or part of that proceeding. The petition shall state the reasons justifying a stay or other temporary remedy.
b. In determining whether to grant a stay pending judicial review, the director shall consider the factors listed in 1998 Iowa Acts, chapter 1202, section 23(5c).
c. A stay may be vacated by the director pending judicial review upon application of the department or any other party.

441—7.21(17A) Food stamp hearings and appeals.
7.21(1) All appeal hearings in the food stamp program shall be conducted in accordance with federal regulation, Title 7, Section 273.15, as amended to February 15, 1983.
7.21(2) All administrative disqualification hearings shall be conducted in accordance with federal regulation, Title 7, Section 273.16, as amended to February 15, 1983.
a. Hearings over disqualification for intentional program violation shall be conducted by an administrative law judge.
b. The department of inspections and appeals shall send a form letter, Notice of Intentional Program Violation Hearing, 427-0364 by certified mail 30 calendar days prior to the initial hearing date.
c. The hearing may be scheduled as an in-person hearing or as a teleconference hearing. If the respondent appears at a teleconference hearing, the respondent must sign Form 427-0415, Agreement for Telephone Hearing, for the hearing to proceed by telephone.

441—7.22(17A) FIP disqualification hearings. This rule applies to family investment program overpayments except for PROMISE JOBS expense allowance overpayments described at rules 441—93.51(249C) and 93.151(249C).
7.22(1) *Scheduling the hearing.* The department of inspections and appeals shall send Form 427-0364, Notice of Intentional Program Violation Hearing, by certified mail 30 calendar days prior to the initial hearing. The hearing may be scheduled as an in-person hearing or as a teleconference hearing. If the respondent appears at a teleconference hearing, the respondent must sign Form 427-0415, Agreement for Telephone Hearing, for the hearing to proceed by telephone.
7.22(2) *Conducting the hearing.* Hearings over disqualifications for intentional program violation shall be conducted by an administrative law judge of the department of inspections and appeals. Administrative disqualification hearings as described at rules 441—46.8(239) and 441—46.28(239) shall be conducted in accordance with rules 7.10(17A) to 7.15(17A) except as otherwise specified. The hearings shall consider each assistance program listed in the referral for intentional program violation. At the administrative

disqualification hearing, the administrative law judge shall advise the assistance unit member or the person's representative of the right to refuse to answer questions during the hearing and that the information may be used in a civil or criminal action by the state or federal government.

7.22(3) *Consolidating hearings.* Appeal hearings and administrative disqualification hearings may be consolidated if the issues arise out of the same or related circumstances, and the person has been provided with notice of the consolidation by the department of inspections and appeals. If the hearings are combined, the time frames for conducting a disqualification hearing shall apply. If the hearings are combined for the purpose of setting the amount of the overpayment at the same time as determining whether or not an intentional program violation has occurred, the assistance unit shall lose its right to a subsequent hearing on the amount of the overpayment.

7.22(4) *Attendance at hearing.* The assistance unit member shall be allowed ten days from the scheduled hearing to present reasons indicating good cause for not attending the hearing. The director or the director's designee shall determine if good cause exists. Unless good cause is determined, when the assistance unit member or the person's representative cannot be located or fails to appear at the scheduled hearing, the hearing shall be conducted without that person. In that instance, the administrative law judge shall consider the evidence and determine if the evidence is clear and convincing that an intentional program violation was committed. If the assistance unit member who failed to appear at the hearing is found to have committed an intentional program violation, but the director or the director's designee later determines that this person or representative had good cause for not appearing, the previous hearing decision shall no longer be valid and a new hearing shall be conducted.

7.22(5) *Hearing decisions.* The administrative law judge shall base the determination of intentional program violation on clear and convincing evidence that demonstrates the person committed, and intended to commit, an intentional program violation.

a. The proposed and final hearing decisions shall be made in accordance with rule 7.16(17A) unless otherwise specified. The department's appeals section shall notify the person and the county office of the final decision within 90 days of the date the person is notified in writing that the hearing has been scheduled.

EXCEPTION: The person or representative may request to postpone the hearing for up to 30 days, provided the request is made at least 10 calendar days before the scheduled hearing date. When the hearing is postponed, the 90-day time frame for notifying the person of the final decision shall be extended for as many days as the hearing is postponed. No action to disqualify shall be taken until the final appeal decision is received finding that the person has committed an intentional program violation.

b. No further administrative appeal procedure shall exist after the final decision of an adverse disqualification hearing is issued. The determination of intentional program violation shall not be reversed by a subsequent hearing decision. However, the person may appeal the case to the Iowa district court. When a determination of intentional program violation is reversed by a court decision, the department's appeals section shall notify the county office with specifics of the court's decision.

441—7.23(17A) No factual dispute contested cases. If the parties agree that no dispute of material fact exists as to a matter that would be a contested case if such a dispute of fact existed, the parties may present all relevant admissible evidence either by stipulation or otherwise as agreed by the parties, without necessity for the production of evidence at an evidentiary hearing. If such agreement is reached, a jointly submitted schedule detailing the method and timetable for submission of the record, briefs, and oral argument should be submitted to the presiding officer for approval as soon as practicable.

441—7.24(17A) Emergency adjudicative proceedings.

7.24(1) *Necessary emergency action.* To the extent necessary to prevent or avoid immediate danger to the public health, safety, or welfare, and consistent with the United States Constitution and the Iowa Constitution and other provisions of law, the department may issue a written order in compliance with Iowa Code section 17A.18 as amended by 1998 Iowa Acts, chapter 1202, section 20(3), to suspend a license in whole or in part, order the cessation of any continuing activity, order affirmative action, or take other action within the jurisdiction of the department by emergency adjudicative order. Before issuing an emergency adjudicative order, the department shall consider factors including, but not limited to, the following:

a. Whether there has been sufficient factual investigation to ensure that the agency is proceeding on the basis of reliable information.

b. Whether the specific circumstances which pose immediate danger to the public health, safety or welfare have been identified and determined to be continuing.
c. Whether the person required to comply with the emergency adjudicative order may continue to engage in other activities without posing immediate danger to the public health, safety or welfare.
d. Whether imposition of monitoring requirements or other interim safeguards would be sufficient to protect the public health, safety or welfare.
e. Whether the specific action contemplated by the agency is necessary to avoid the immediate danger.
7.24(2) Issuance of order.
a. An emergency adjudicative order shall contain findings of fact, conclusions of law, and policy reasons to justify the determination of an immediate danger and the department's decision to take immediate action.
b. The written emergency adjudicative order shall be immediately delivered to persons who are required to comply with the order by using one or more of the following procedures:
(1) Personal delivery.
(2) Certified mail, return receipt requested, to the last address on file with the department.
(3) Certified mail to the last address on file with the department.
(4) First-class mail to the last address on file with the department.
(5) Fax. Fax may be used as the sole method of delivery if the person required to comply with the order has filed a written request that department orders be sent by fax and has provided a fax number for that purpose.
c. To the degree practicable, the agency shall select the procedure for providing written notice that best ensures prompt, reliable delivery.
7.24(3) *Oral notice.* Unless the written emergency adjudicative order is provided by personal delivery on the same day that the order issues, the department shall make reasonable immediate efforts to contact by telephone the persons who are required to comply with the order.
7.24(4) *Completion of proceedings.* After the issuance of an emergency adjudicative order, the agency shall proceed as quickly as feasible to complete any proceedings that would be required if the matter did not involve an immediate danger. Issuance of a written emergency adjudicative order shall include notification of the date on which agency proceedings are scheduled for completion. After issuance of an emergency adjudicative order, continuance of further agency proceedings to a later date will be granted only in compelling circumstances upon application in writing.
These rules are intended to implement Iowa Code chapter 17A as amended by 1998 Iowa Acts, chapter 1202.

Attachment 9

Health Plan Appeal and Grievance Procedures

Health Plan Appeals and Grievance procedures

	Iowa Health Solutions	John Deere Health Plan	Wellmark Blue Cross Blue Shield
Definition	Any questions, concerns and/or problems regarding coverage and benefits.	Any questions or concerns regarding coverage decisions, preauthorization decisions, or any action concerning the provision of health care services, or other matters concerning the operations of health plan.	Denial of benefits, or disagreement with decision to reduce benefits, or complaint regarding a claim, provider or service provided by Wellmark
Who can file a complaint or an appeal	A member, a primary care physician (PCP), attending physician or hospital.	An Enrollee's physician, family member or other individual may act as the Enrollee's representative to assist in filing a complaint on behalf of the Enrollee.	Enrollee or someone appointed by the Enrollee
Type of appeal			
Informal	(First level of appeal for IHS) Member contacts Member Services with question, concern or problem.	Enrollee contacts Customer Service Department or other health plan employee with an inquiry.	Enrollee calls Customer Service Department
➢ **Decision maker**	Member Services.	Customer service department. If Enrollee is dissatisfied with the response, the enrollee must always be advised of next step in complaint process.	Customer service department researches and resolve issue and notify Enrollee of right to appeal if appropriate
Standard or First Level Appeal Process	(Second level of appeal for IHS) If not satisfied with answer received from first level of appeal, may submit a request for a second level appeal. Needs to be in writing.	Used for all cases that are not life threatening or severe enough to seriously jeopardize the member's health and/or ability to regain maximum function. Written expression of dissatisfaction with health plan requesting that a decision be overturned.	If enrollee is not satisfied with resolution of a complaint, enrollee may contact customer service department by phone or submit a written appeal by completing an Enrollee Appeal Form.
➢ **Time frames for filing an appeal**	No later than 30 working days after the date of the action, decision or incident occurred with which the person is unhappy.	Complaint form shall be filed within 90 days from date the problem in question occurred. The form shall be signed and the facts listed.	The Enrollee Appeal Form must be filed within 120 days of the complaint decision.

	Iowa Health Solutions	John Deere Health Plan	Wellmark Blue Cross Blue Shield
➢ **Decision maker**	Iowa Health Solutions Grievance Committee	Health plan's medical director or physician advisor when medical review is needed or appropriate. When the issue requires an administrative the appropriate department makes the decision. Persons involved in the initial determination may not review the appeal.	Wellmark Blue Cross and Blue Shield Enrollee Appeal Committee
➢ **Time frame for decision**	Within in 15 days of receiving grievance for medial services. All other types of grievances will be made within 30 days of receipt of grievance.	Within 30 calendar days of receipt of complaint with details of the decisions and further appeal process available to Enrollee, should decision not be in Enrollee's favor. The written decision may be extended by ten business days to obtain documentation records necessary to resolve the case and the delay is in the interest of the Enrollee.	30 calendar days from receipt of form, if no additional information is needed. If additional information is not received in time allowed, Wellmark will make a decision.
➢ **Notification of decision**	Letter will be made stating the Committee's decision and the reason for the decision.	Written letter to all parties involved.	
Expedited Appeal	May be requested for any denial of utilization management and there is a urgent situation.	Requested to accommodate the urgency of the situation when the standard appeal process will cause delay in the rendering of health care that would be life threatening or severe enough to seriously jeopardize the member's health and/or ability to regain maximum function.	May be requested anytime there is denial in utilization management and the situation is urgent.
➢ **Who can file a complaint or an appeal**	Member, pcp, attending physician or hospital	Enrollee or physician contacts JDHP verbally or in writing with request for expedited appeal. An enrollee's physician, family member or other individual may act as the Enrollee's representative to assist in filing an appeal on behalf of the Enrollee.	Enrollee, physician or hospital

	Iowa Health Solutions	John Deere Health Plan	Wellmark Blue Cross Blue Shield
➢ **Decision Maker**	Medical director or physician advisor	Medical director or physician advisor	Medical director or physician advisor
➢ **Time frame for decision to be made**	Within 72 hours of request	Every attempt will be made to provide a decision for expedited appeals that are emergent in nature within 24 hour turnaround of receipt of complete medical information necessary to render a decision.	Within 72 hours of request
➢ **Notification of decision**	By phone or fax, followed by written decision.	The Enrollee will be informed of the decision by telephone or fax within 72 hours. In addition, a written decision is issued within 2 business days detailing the decision. If ruling is not in favor of the Enrollee, the Enrollee has 14 days to appeal the decision orally or in writing.	By phone or fax, followed by written decision.
Second Level Appeal	(3rd level appeal for IHS) If member, pcp, attending physician or hospital is not satisfied with answer from 2nd level appeal	An appeal to Grievance Committee is a further request from an Enrollee than an unfavorable Level 1 complaint decision be reversed.	If not satisfied with the resolution of first level appeal, Enrollee may appeal to the Enrollee Appeal Committee of the Board.
➢ **Time frame to file a second level appeal**	In writing within 15 days of decision of the second level appeal.	If the Enrollee is not satisfied with the outcome of the decision he/she has 14 days from the date the decision was issued in which to file a formal appeal to the Enrollee Grievance Committee of JDHP.	Must be filed within 30 calendar days of receipt of decision
➢ **Decision maker**	Iowa Health Solution's Physician Advisory Group.	The Grievance Committee. Grievances will not be heard or voted upon unless at least 50% of the voting individuals of the committee are Enrollees who are consumers. The Grievance Committee shall have authority to resolve by majority vote grievances filed by Enrollees. The panel will include participants who were not involved in the previous decisions. A	Enrollee Appeal Committee of the Board

	Iowa Health Solutions	John Deere Health Plan	Wellmark Blue Cross Blue Shield
		physician who was not previously involved will review the case when it involves a denial of services or treatment based on medical necessity. At least one practitioner in the same or similar specialty that typically manages the medical condition, procedure or treatment must be involved in the review at one level of the appeal process.	
➢ **Time for decision to be made**	Within 30 days of receipt of the second level appeal	Grievance Committee Hearing should be held within 45 days of the receipt of the appeal letter. An additional 30 day extension is avialable due to a delay in obtaining documents necessary for the Grievance Committee to make a deterimination.	The Enrollee Appeal Committee of the Board will meet within 30 working days of receiving the appeal. The Enrollee Appeal Committee of the Board will issue a final decision and notify the Enrollee by letter within five business days of the meeting.
➢ **Hearing notice information**	A member may attend the meeting with the Grievance Committee or Physician's Advisory Group. This can be in person or via teleconference.	The Enrollee shall be notified, at the time of the hearing, of the name and affiliation of the Enrollee Grievance Committee members. JDHP shall not present any evidence without the Enrollee having been given the opportunity to be present. Each party may present his or her case as to why the decision rendered should be sustained or rejected. The Enrollee shall have the right upon written request to review all documents. The Enrollee may submit issues and comments in writing.	The Enrollee or someone acting on behalf of the enrollee may participate in the meeting of the Enrollee Appeal Committee of the Board. The Enrollee will receive a letter within five working days or receipt of appeal, acknowledging the receipt of the second level appeal and the date of the appeal meeting.
➢ **Notification of decision**	Letter will be mailed stating the Group's decision and the reason for the decision.	Final disposition letter detailing the reasoning of the decision, is mailed to the Enrollee within five business days after final decision by the Grievance Committee. The letter notifies the member of any further appeal	

	Iowa Health Solutions	John Deere Health Plan	Wellmark Blue Cross Blue Shield
		rights they may have.	
External Review	(Fourth level of appeal for IHS) If not satisfied with answer of third level appeal, a fourth and final appeal can be made to the Department of Insurance. The fourth level of appeal must be submitted in writing within 15 days of the decision of the third level appeal.	JDHP shall not preclude the Enrollee from filing a complaint with the Department of Insurance nor shall it preclude the Department of Insurance from investigating a complaint persusant to its authority under section 4-6 of The HMO Act.	If the Enrollee has exhausted the Plan's appeal process regarding a denial of benefits based on medical necessity, the Enrollee or the provider acting on behalf of the Enrollee may request a decision of the Wellmark's decision with the Iowa Insurance Commissioner. This request must be filed in writing no later than 60 days following Wellmark's decision.
Other review		If a member is dissatisfied with the decision of the Member Grievance Committee, he or she may file a request for arbitration with JDHP in writing within six months of the date of the decision. Arbitration shall be conducted in accordance with the Rules of the American Health Lawyers Association Alternative Dispute Resolution Service. The parties waive their right to jury trial, except for enforcement of the decision of the arbitrator.	